Canadian Hospital

Journal of The Canadian Hospital Association

February, 1960

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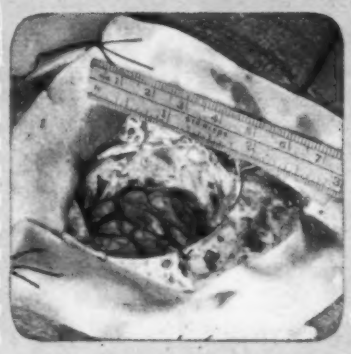

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The Canadian Hospital Association is the federation of hospital associations in Canada and the Canadian Medical Association in co-operation with the federal and provincial governments and voluntary non-profit organizations in the health field.

Canadian Hospital

THE JOURNAL OF THE CANADIAN HOSPITAL ASSOCIATION

Editorial and Secretarial Offices:
280 Bloor St. West, Toronto 5, Ont.

Contents

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Subscription rates: $3.00 a year first subscription; each additional one $1.50—in Canada, United States and Great Britain.

Business Manager: Charles A. Edwards
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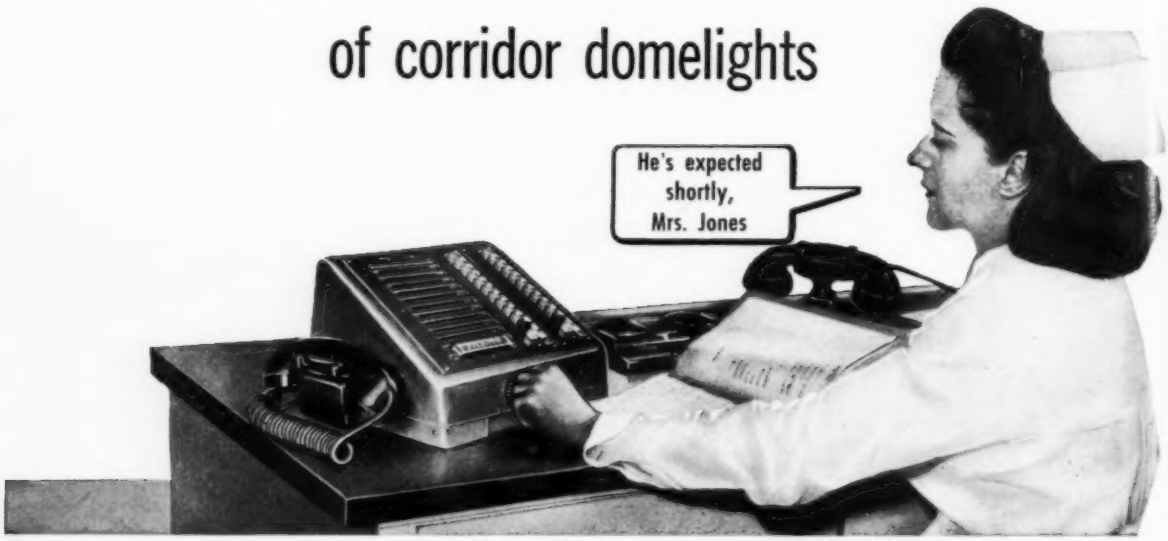

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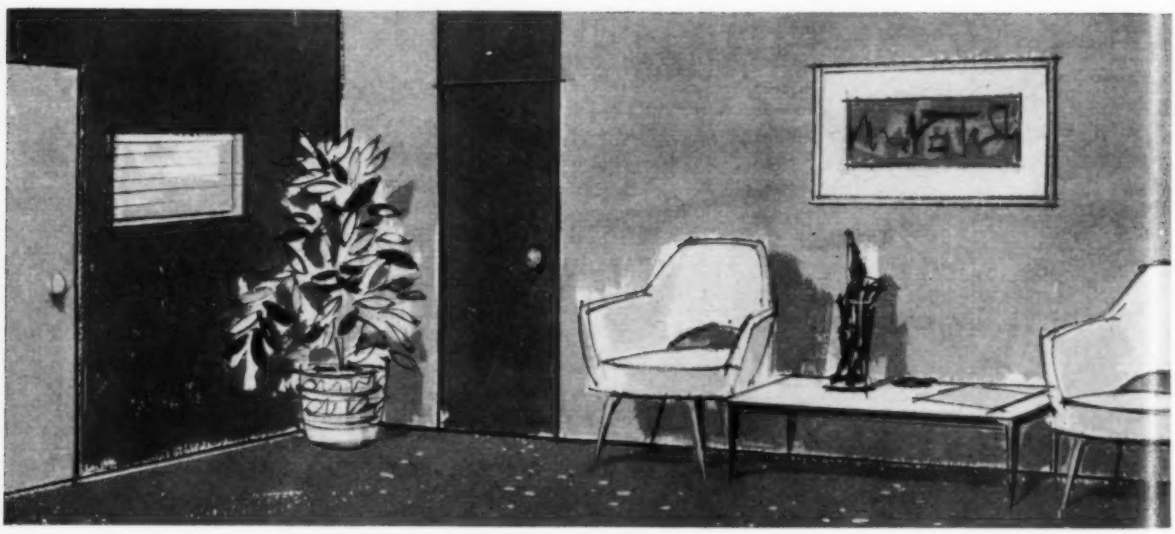

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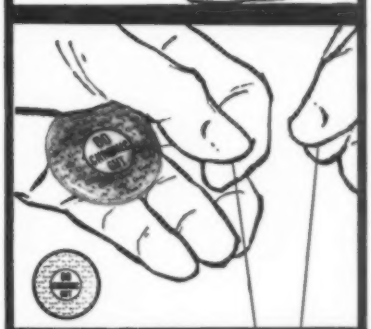

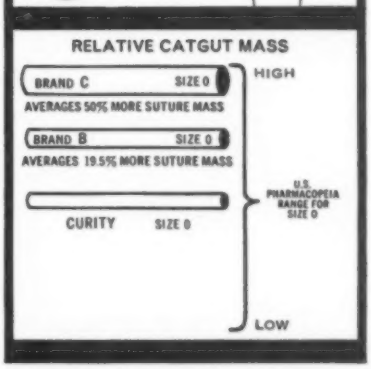

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Notes About People

At Wellesley Hospital

Now that ties with the Toronto General Hospital have been severed, Wellesley Hospital will have its own administrator. He is G. E. Thornton who was the administrative assistant when the Wellesley Hospital was a unit of the Toronto General. Mr. Thornton will also act as secretary-treasurer.

The president of the board of directors at the hospital is H. M. Turner.

Change for A. T. Story

Alfred T. Story is the new assistant administrator at Hotel Dieu Hospital, St. Catharines, Ont. Before this, he was business manager at the St. Catharines General Hospital, St. Catharines, Ont.

Mr. Story, who has taken the Canadian Hospital Association's extension course in hospital organization and management, has also held posts at the Guelph General Hospital, Guelph, Ont., and at the Owen Sound General and Marine Hospital, Owen Sound, Ont.

Dr. G. S. Cameron Retires

Dr. G. S. Cameron, who has been on the board of governors of Peterborough Civic Hospital, Peterborough, Ont., since it was constituted in 1945 and who was on the board of the original Nicholl's Hospital from 1908, has retired. Fellow members of the board held a reception in his honour where he was presented with an inscribed silver tray in recognition of the many years' service he had given to the hospital and the city of Peterborough.

Dr. Cameron graduated in medicine at Trinity University, Toronto, in 1896. He stimulated the founding of the Peterborough County Medical Society and was an active member of the Ontario Medical Association as well as its president in 1918. He is a charter member of the Royal College of Surgeons (Canada) and in 1939 he was made a life member of the Ontario Medical Association. He became a senior member of the Canadian Medical Association in 1944.

Captain J. E. Stone Retires

Captain J. E. Stone, C.B.E., M.C., F.S.A.A., F.H.A., has retired from the post of honorary secretary and treasurer of the International Hospital Federation. He has held the position for 11 years.

Captain Stone is the author of a number of well-known books on hospital work and practice—*Hospital Organization and Management* and *Hospital Accounts and Financial Administration*. In 1958 he resigned from King Edward's Hospital Fund for London. He is an honorary fellow of the American College of Hospital Administrators and an honorary member of the American Hospital Association.

At the Kingston General

Peter R. Carruthers, who was recently appointed administrative assistant at the Winnipeg General Hospital, Winnipeg, Man., is now assistant to the superintendent at the Kingston General Hospital, Kingston, Ont. Mr. Carruthers is a graduate of the course in hospital administration, School of Hygiene, University of Toronto.

B. C. Tetro, who has been with the hospital many years, has been made comptroller. William Robb, who has also been with the hospital a number of years and who is a graduate (1958) of the Canadian Hospital Association's extension course in hospital organization and management, has accepted the post of administrative assistant. The new office manager at the Kingston General is P. H. Turner. Mr. Turner, who has been associated with the hospital for two years, is enrolled in the first year of the C.H.A.'s extension course.

At the beginning of the year, Dr. S. L. Vandewater went to the Kingston General Hospital from the Toronto General Hospital to fill the position of head of the department of anaesthesia. He will also hold the appointment of associate professor, Queen's University Medical School.

John Law to Head Hospital for Sick Children

A new director has been appointed at the Hospital for Sick Children, Toronto, Ont. He is John Law who leaves a position as associate director of the Yale-New Haven Medical Centre to come to Toronto. In 1952 Mr. Law spent several months at the Hospital for Sick Children acting as a consultant.

The hospital has been administered by the assistant superintendent, C. A. Sage, since the death last summer of its former superin-

(continued on page 18)

At the presentation to Dr. G. S. Cameron. l. to r.: M. J. Swanston, chairman of the board of governors, Peterborough Civic Hospital, Peterborough, Ont.; Dr. G. S. Cameron; and T. T. Roger, treasurer of the board of governors, Peterborough Civic Hospital.

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St. Vincent's Hospital, Vancouver, B.C. Edwards equipment installed includes doctors' register, fire alarm, nurses' call and clock systems.

Nurses' Master Console of Edwards Audio-Visual Nurses' Call System.

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(continued from page 12)

tendent, Dr. G. Currie. Mr. Sage, who is a financial expert, will now hold the title of associate director.

Mr. Law has had much experience in hospital administration. He has lectured on the subject at the School of Medicine and Dentistry at the University of Rochester and in the School of Public Health, Yale University.

Retirement of J. H. Roy

J. H. Roy, who received the George Findlay Stephens Memorial Award in 1958, has retired from his post as director general of Hôpital St-Luc, Montreal, Que. His successor is Dr. J. Paul Laplante.

Mr. Roy has been with the hospital since 1915 and is a co-founder of the Quebec Hospital Service Association (Blue Cross) and of the Quebec Hospital Association. His friends in the hospital field will wish him many years of happy leisure.

Male Nursing Director

Maunsell Gerrow has been made director of nursing at the Ajax and Pickering General Hospital, Ajax, Ont. He has taken a course at the University of Toronto in nursing service and administration.

From 1942 to 1946 Mr. Gerrow served in the R.C.A.F. medical services. After the war he joined the Department of Veteran's Affairs at Westminster Hospital, London, where he worked with psychiatric patients. After this he went to the Ontario Hospital in Whitby and then, from 1952 to 1959, he was charge nurse on the medical floor at the Oshawa General Hospital, Oshawa, Ont.

New Kitimat Administrator

Donald A. Robertson has been appointed administrator of the Kitimat Hospital, Kitimat, B.C. He replaces Donald S. Gray who resigned recently.

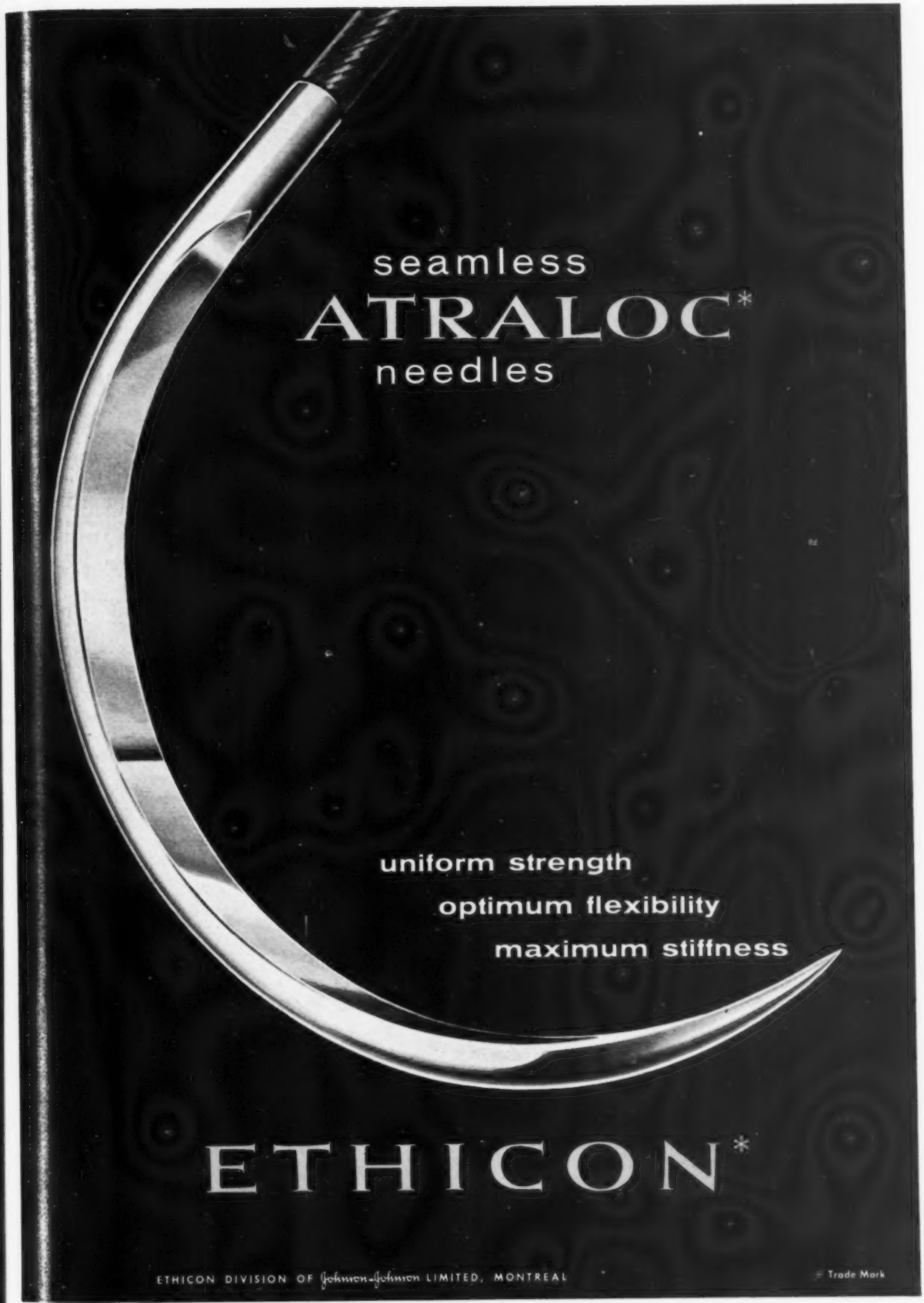
Mr. Robertson attended the course in hospital administration at the School of Hygiene, University of Toronto, from 1953-55. After completing his administrative residency at St. Mary's Memorial Hospital of Montreal, Que., he remained on the staff as administrative assistant and in 1958 he was appointed assistant administrator.

Donald A. Robertson

New Post in O.H.S.C.

The new post of general manager, Ontario Hospital Services Com-

(concluded on page 28)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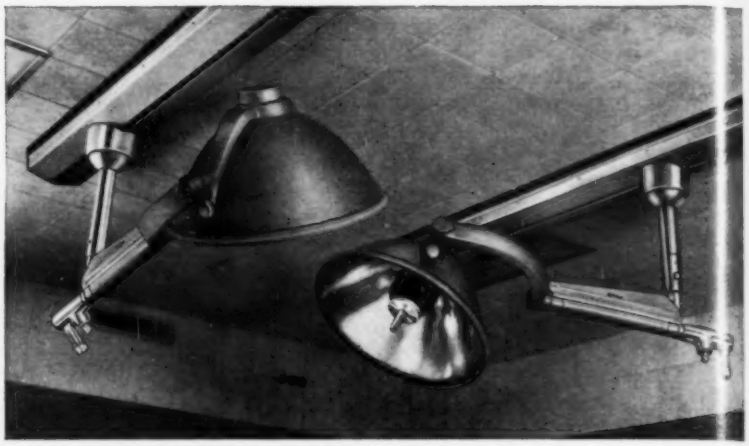

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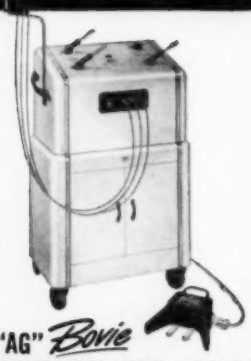

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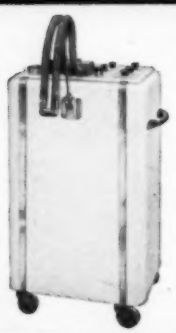

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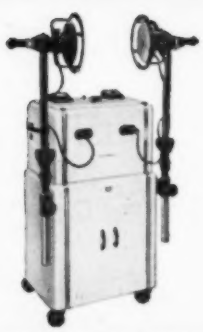

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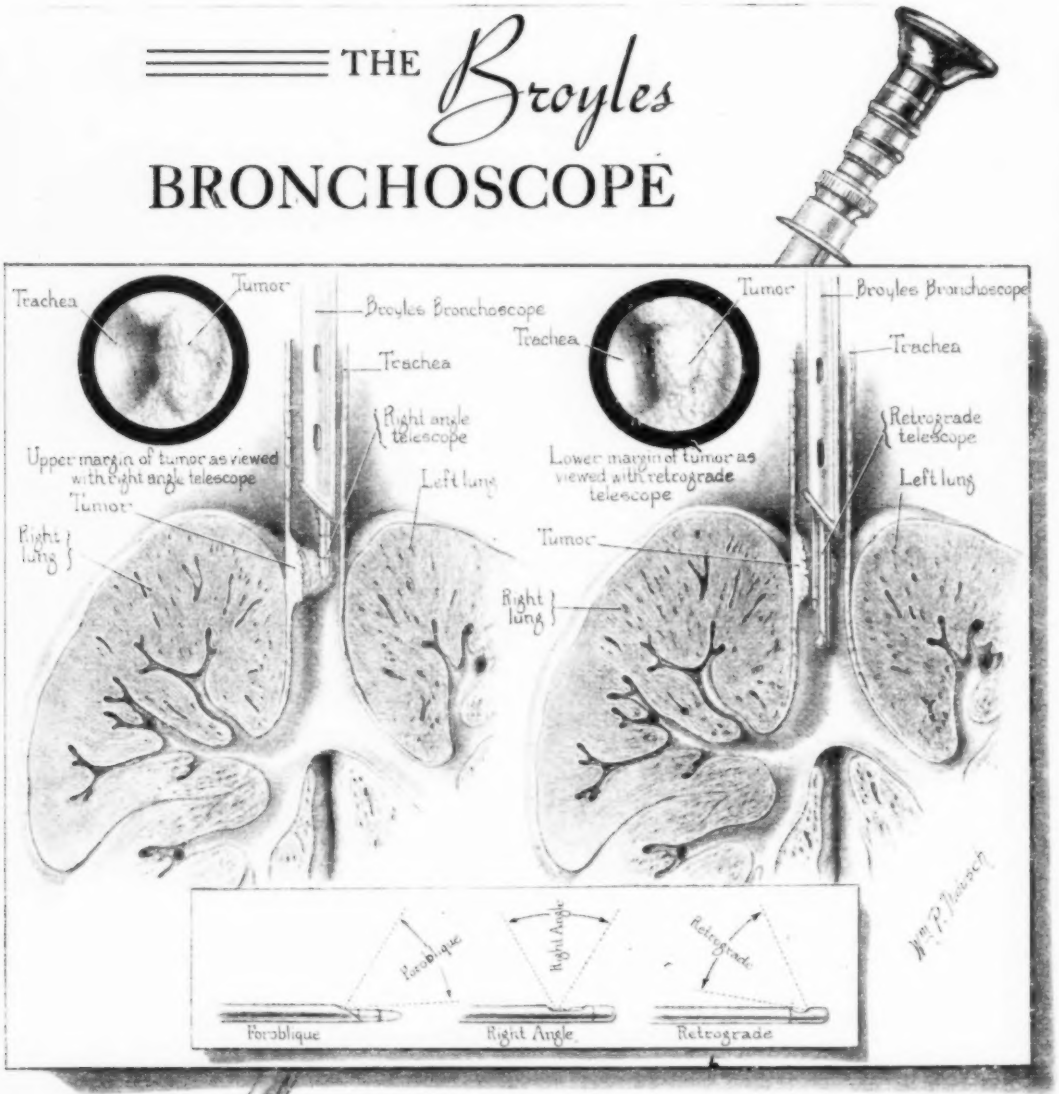

The illustration above shows the Broyles Bronchoscope and the use of right angle and retrograde telescopes in evaluating a tumor of the trachea.

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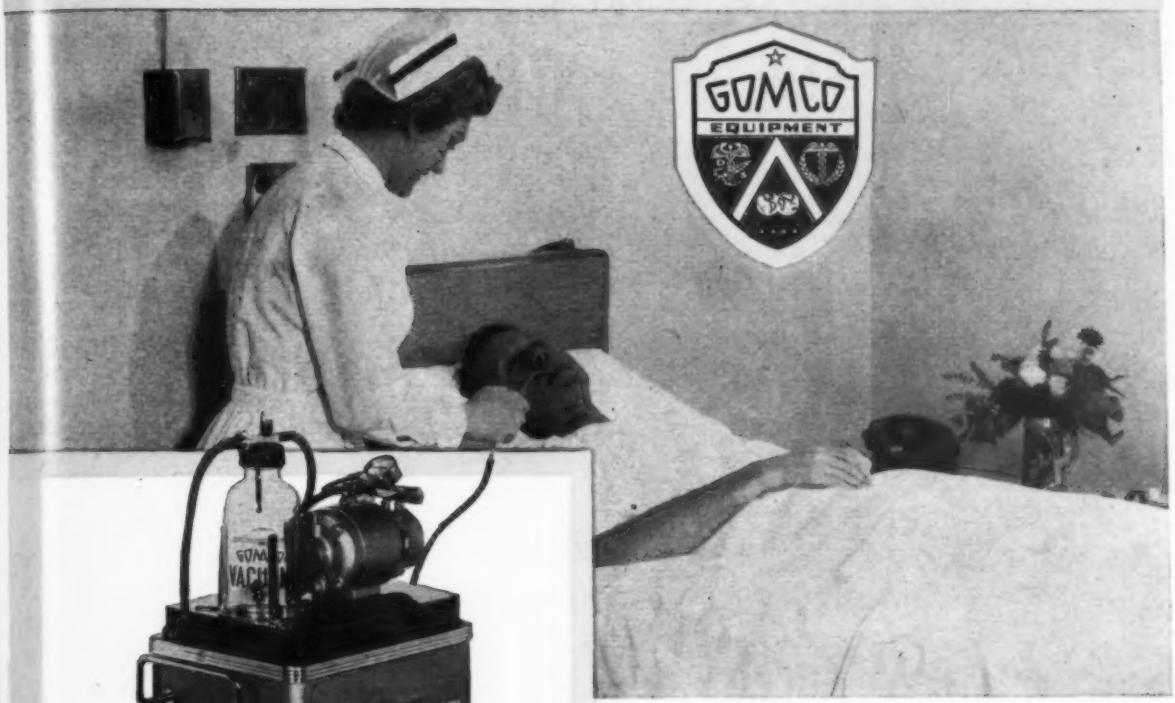

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Clay-Adams
NEW YORK 10

People

(concluded from page 18)

mission, has been filled by David W. Ogilvie. Mr. Ogilvie was the director of the commission's hospital insurance branch.

Succeeding Mr. Ogilvie as director of hospital insurance is Robert E. Foster, former assistant director.

New Post for M. G. Taylor

Malcolm G. Taylor, Ph.D., associate professor of political economy at the University of Toronto, will leave this position to take up new duties as principal and vice-president of the new University of Alberta in Calgary. He will assume his new post next summer. It is expected that the new university will be granting its own degrees in two years.

Dr. Taylor, who has been on the teaching staff of the University of Toronto since 1951, has also been very active in the health field. He is the author of two books on health insurance and is working on a third.

In Montreal

The new chief of the surgical clinic at Hôpital Jean Talon in Montreal, Que., is Dr. Jean Darche. He was until recently chief surgeon at Hôpital Sainte-Marie, Trois-Rivières, Que. In Montreal he will continue with his surgical practice.

• Donald G. Coolidge has been appointed secretary-administrator of the Hanna Municipal Hospital, Hanna, Alberta. The position was formerly held by the late H. J. Peddie.

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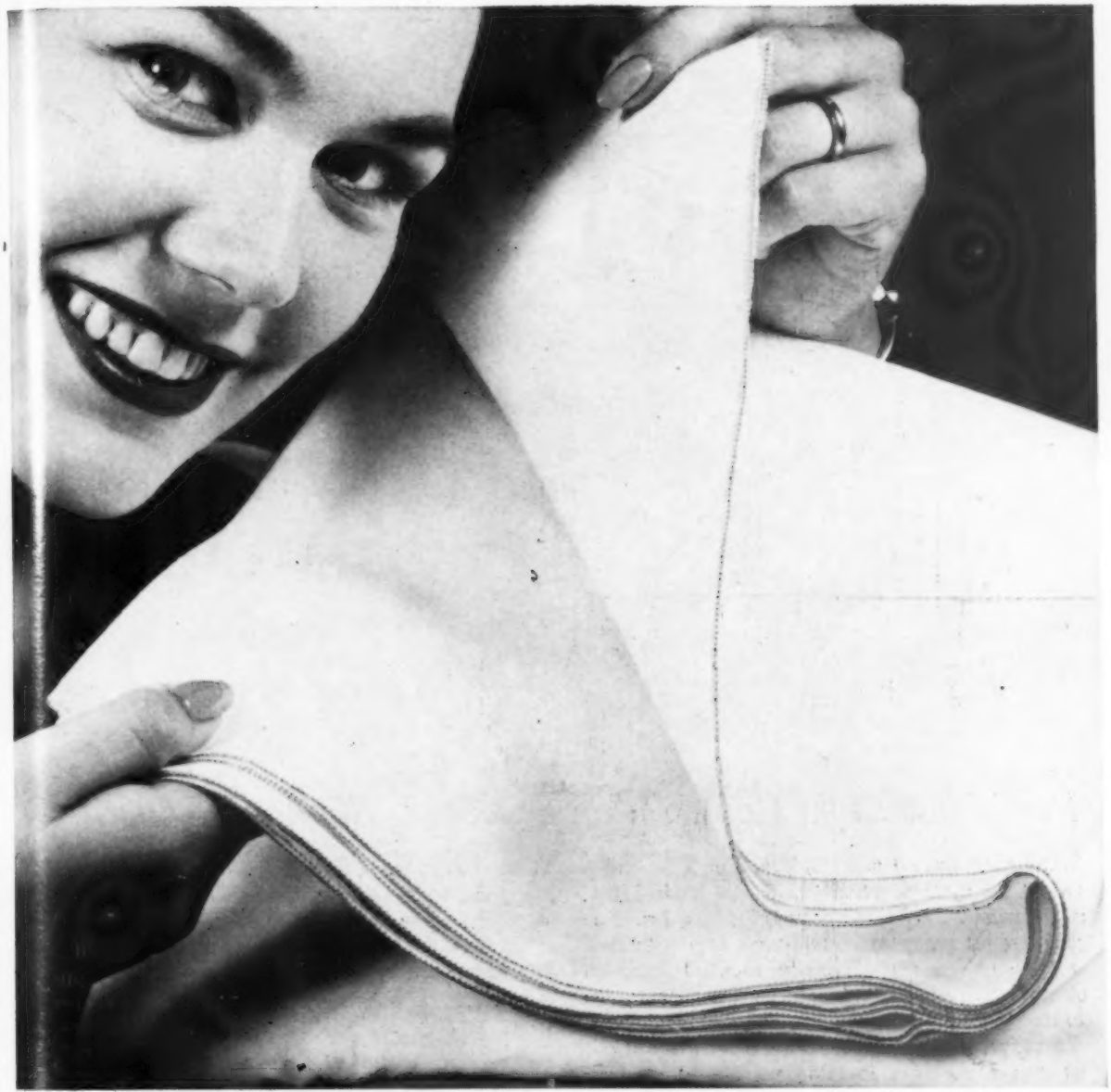

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Canadian Hospital

Obiter Dicta

Mental Health Year — 1960

THE World Federation for Mental Health has designated this year, 1960, as Mental Health Year. The purpose in observing this Year is to give added stimulus to all activities related to mental health, including research, with a maximum of international co operation and exchange of ideas. The World Federation for Mental Health is a voluntary organization of mental health and professional societies in 43 countries. It sparked the idea of observing the special Year and sought and obtained the active support of the World Health Organization and many other international agencies, as well as that of governments. It is hoped that during 1960 the focus of world public opinion can be brought to bear upon the importance of good mental health.

The attitude of society towards mental illness and positive mental health has varied during the centuries. Occasionally there has been concern for the welfare of the mentally afflicted, but more commonly the response has ranged from cold indifference to active revulsion, coupled with a desire to set the mentally sick apart from their fellow men. It is undoubtedly true that in the past few decades the attitude toward mental illness has generally improved. There is increasing recognition of the extent to which mechanization has led, in many countries, to stress and anxiety, with consequent social disturbance. Research into problems relating to mental illness has been intensified.

The World Federation believes the time has come for a reconsideration of values, for fact finding, for the development of a better informed public, and for social measures based on knowledge developed in this special Year. They have asked for the support of newspapers and magazines.

In this issue we are featuring articles covering the work of mental health authorities in one of our large Canadian provinces. These articles give an authoritative account of the many efforts being made to prevent and combat mental illness in Ontario. We believe that this issue will be of interest and of value to all our readers from coast to coast. We are indebted to the staff of the Mental Health Division, Department of Health, Ontario, for planning and achieving this symposium. We are grateful also to the contributors.

Canadian Accreditation Program Advances

THE Canadian Council on Hospital Accreditation held its annual meeting January 15th, when accreditation activities during the first year of the all Canadian program were reviewed. The various reports indicated an increasing interest in the program on the part of Canadian hospitals. During 1959, 134 hospitals were visited and at 27 of these initial surveys were made. There was also a substantial increase in the number of enquiries. Dr. W. I. Taylor, executive director, reported that in 1960 some 170 hospitals would be surveyed. In addition to the regular survey work, 36 hospitals were reviewed for the Canadian Medical Association with respect to intern training; 34 were reviewed for training of laboratory technologists; and 12 were reported on for the Royal College of Physicians and Surgeons of Canada with regard to residency training.

The financial statement for 1959 reflected the increasing work of the Council. Expenditures were some $49,000, income was $35,000, with an excess of expenditure over revenue of $14,000. The Council adopted a budget for 1960 with expenditures estimated at $58,000 and a revenue of $49,000. Because of a further projected increase in work load for 1961, Council appointed a special committee to study various methods which might be adopted to augment funds for 1961 and thereafter.

Several committees reported on their work. Dr. Gerald LaSalle presented a set of medical staff by-laws which his committee had worked out. These were approved by Council. They are being printed and made available to Canadian hospitals this month.

We believe the all Canadian program on hospital accreditation has developed very well in its first year of operation. The increasing interest on the part of hospitals is very encouraging. Council accepted with regret the resignation of Dr. Karl E. Hollis as consultant. Dr. Hollis by his energy and enthusiasm did much to push forward the accreditation movement in Canada. To Dr. W. I. Taylor and members of Council, we extend our best wishes for the continuing success of the program in 1960.

Care of the Mentally Ill

in Ontario

New Administration Building, 999 Queen Street W., Toronto.

History of Treatment

B. H. McNeel, M.D.,
and
C. H. Lewis, M.D.,
Toronto, Ont.

In the Province of Upper Canada

IN 1830 the first positive step toward providing for the care of the mentally ill was taken. In that year the House of Assembly passed an Act authorizing payment for destitute lunatics in county jails. Between 1830 and 1839 numerous unsuccessful attempts were made toward the establishment of a mental hospital. During these years in the legislature four notices of motion were not presented and three which were presented were defeated, but the public desire to assist the mentally ill slowly gained momentum.

On March 15, 1839 a resolution authorizing a grant of £3,000 toward the erection of a lunatic asylum carried a large majority. Three commissioners were duly appointed and on April 16, 1840 they wrote to the College of Physicians and Surgeons of Upper Canada soliciting advice. The College in turn appointed three members and they recommended a site.

There is no available record of further activity by this Committee, probably because the Lieutenant-Governor favoured building the hospital at Kingston rather than Toronto. On June 10, 1840, the College of Physicians and Surgeons wrote to the Lieutenant-Governor, at some length, strongly urging the choice of Toronto. On November 3, 1840, the original Commissioners were replaced. Toronto was chosen as the site of the Mental Hospital.

In Ontario

The present mental hospital system dates from Confederation, when among the exclusive powers vested in the provincial legislature, by the British North America Act, was "The establishment, maintenance and management of asylums." Prior to 1867 the mentally ill were cared for jointly by the United Provinces of Upper and Lower Canada.

A significant change under the new system was the appointment in 1868 of an Inspector under the Provincial Secretary to supersede the Board of Inspectors under the Lieutenant-Governor. Thus the hospitals came under direct government supervision.

In 1871 the Legislature passed "An Act Relating to Lunatic Asylums and the Custody of the Insane." This act definitely defined the duties of asylum officers, the terms upon which patients were to be admitted, the rate of their maintenance and provided for the proper administration of estates of the insane by the Inspector.

In 1913 "An Act Respecting Provincial Hospitals for the Insane and the Custody of Insane Persons"

Dr. McNeel is chief of the Mental Health Division, Department of Health. Dr. Lewis is assistant director, Ontario Hospitals, in the same department.

For the history of the care of the mentally ill, prior to 1920, the authors wish to acknowledge their indebtedness to "The Institutional Care of the Insane" in the United States and Canada by Hurd, Drewry, Dewey, Pilgrim, Blumer and Burgess—Vol. IV — Johns Hopkins Press, Baltimore, Md., 1917.

(Hospitals for the Insane Act) contained several reforms. Among these are the substitution of the term "hospital" for "asylum"; provision for the admission of voluntary patients; and the forbidding of the confinement of any person alleged to be insane in a gaol, lock-up, prison or reformatory while the question of sanity is being determined and while awaiting admission to a hospital. The same act reaffirms that the Inspector of Asylums shall be, ex-officio, the committee of every insane person in an asylum who has no other committee or unless the High Court of Division shall appoint a committee for such patient.

The same session of the Legislature passed an act revising that in force respecting private sanitaria for mental diseases, drug and alcoholic habitués. This placed all such institutions under the supervision of the Inspector of Asylums and a Board of Visitors.

The Reception Hospitals for the Insane Act was passed in 1914 and amended to become the Psychiatric Hospital Act in 1926. Mental Hospitals were transferred from the jurisdiction of the Department of the Provincial Secretary to the Department of Health in 1932.

The "Hospitals for the Insane Act" was superseded by the "Mental Hospitals Act" on August 1, 1935.

Toronto Asylum and Its Branches

In 1824 the York gaol was built on the north side of King Street opposite the site of the present King Edward Hotel, and a number of lunatics were confined in its basement cells. On February 8, 1840, the House of Assembly, through the Speaker, petitioned the Governor-General of British North America "to direct that a suitable building be provided forthwith as a temporary asylum for the many unfortunate persons afflicted with lunacy in this province."

When a new gaol was opened at the east end of the city it became a question whether the lunatics should be transferred with the prisoners. The Honourable R. S. Jamieson, Chairman of the Board of Commissioners for the erection of a lunatic asylum, took upon himself the responsibility of advising the sheriff of the Home District to leave them where they were, and having secured the building fitted it up as a temporary asylum for their use. This institution, which opened on January 21, 1841, by the enrolment of 17 patients, before confined as prisoners, was the first lunatic asylum in Upper Canada, and was known as "The Temporary Lunatic Asylum, Toronto."

The old gaol afforded accommodation for barely 100 patients and in 1846 it became necessary to seek additional quarters. The increased accommodation required was procured by occupying, for asylum purposes, the east wing of the Parliament Buildings which had been abandoned in 1841 after the union of the provinces. Work was begun in June 1845 on a new building at the west end of the city which was aptly called "The Permanent Lunatic Asylum, Toronto." By January 26, 1850, the main building was sufficiently advanced to admit of the transfer of the patients, 211 in number, from the improvised accommodation that they had been occupying. The wings were not completed until 1869 and 1870.

Crowding again became a problem, and some temporary relief was obtained by transferring 70 patients to accommodation in the University of King's College, where they were visited daily by a medical officer.

Meanwhile, it became necessary to obtain still more space and the old military barracks at Fort Malden near Amherstburg was converted into an auxiliary asylum. Malden continued a branch of and was fed from the Toronto Asylum until September 24, 1861, when by order of the Governor-General in Council, it was made an independent institution for south-western Ontario.

On August 13, 1861, a third branch asylum was established at Orillia. It was in a three storey brick building originally designed as an hotel but left unfinished, in what is now Couchiching Park.

Kingston

In 1841 John S. Cartwright, Esq., member for Lennox and Addington in the first Parliament after the union of the Canadas, built for himself a fine stone mansion with very handsome stables also of stone. These were erected on the Cartwright estate known as "Rockwood". In October 1856, 33 acres of this estate, including the buildings, were purchased by the Crown as a site for a criminal lunatic asylum. Shortly thereafter, the stables were fitted up for the reception of 24 female patients, the male patients having been already located in the basement of the nearby Penitentiary. In September 1859, the erection of the asylum was begun, and it was erected chiefly by convict labour, occupying eight years in construction. It was intended for insane criminals and dangerous lunatics only. The first patients were admitted in 1862, but it was not until early in 1868 when the stable-asylum was vacated.

Rockwood was intended for criminal insane. The Toronto asylum was, however, crowded and travelling was inconvenient. Relatives and friends of lunatics in eastern Ontario solved the problem by the simple expedient of having the lunatic committed to gaol as dangerous, whether really so or not. To prevent this the inspectors, as early as 1862, recommended that Rockwood be used as a general asylum. At Confederation, the Board of Inspectors of Asylums, Prisons, et cetera, became the directors of penitentiaries, and the asylums and gaols passed into the hands of the provincial government, with the exception of Rockwood, which as a part of the penitentiary remained under Dominion supervision.

Crowding, however, was an ever present problem and the insane, particulary in the western district, began to accumulate in gaols. Negotiations were accordingly entered into with the Dominion Government whereby, in 1868, the Act Respecting a Lunatic Asylum for Criminal Convicts" was repealed and 100 to 150 insane were transferred from gaols to Rockwood. They were to be kept separate from the criminal insane and the province paid for their maintenance. This "farming-out" system was shortly deemed unsatisfactory and on July 1, 1877, the Ontario Government took possession of Rockwood, purchasing the buildings and grounds. The 22 insane convicts of unexpired sentence were then transferred to the penitentiary, where a special detached building was later provided.

London Asylum

London Asylum, the third in point of seniority of the existing Ontario institutions, is based on the old makeshift Malden Asylum, originally opened in 1859 as a branch of Toronto Asylum, but made an independent establishment in 1861.

In conformity with section nine of the "British North America Act" in 1868 Ontario adopted the present system of direct government supervision of asylums, gaols, and other public institutions.

In his first report, Inspector

J. W. Langmuir urged upon the government the pressing need of increased accommodation for the insane, especially in the western part of the province. In 1869 the Legislature made an appropriation toward the immediate erection of a new asylum in London. For the purpose, 300 acres were purchased on the north side of the Governor's Road, about two miles east of the city.

On November 18, 1870, the 119 inmates of the Orillia branch asylum were admitted. They were followed on the 23rd, by the 244 from Malden; Orillia and Malden were then closed. London Asylum was enlarged in 1872 by the creation of a department for idiots, which was entirely isolated from the main asylum, but under its management and control. This structure, though insignificant in itself, being capable of housing but 38 inmates, is yet of considerable interest, having been the first building erected in the province for the reception and care of defectives only.

Hamilton Asylum

Hamilton Asylum found its origin in an effort on the part of the temperance advocates of the province to provide a place of detention for inebriates.

At the session of the Legislative Assembly in 1867-68, a petition presented by the Congregational Union of Canada for the establishment of an asylum for inebriates was referred to a Parliamentary committee. Nothing, however, was done in the matter, and between July 1872, and February 1873, some 50 petitions to the same effect as the original, and signed by residents from all parts of the province, were presented. This resulted in a decision to procure a site and commence the erection of a building in the vicinity of Hamilton; 100 acres was purchased on the brow of the escarpment and the building was ready for occupancy in the fall of 1875.

The number of inebriates admitted was small while the gaols and many private homes contained many insane persons. Inspector Langmuir persuaded the government that the needs of the lunatics were far more pressing than those of the dipsomaniacs and the building was devoted to the care of the insane.

On March 17, 1876, the date of opening for the reception of chronic cases only, 210 patients were transferred from the Toronto, Kingston and London Asylums. The building was enlarged in 1878, and in June 1879, due to overcrowding at Orillia, the basement of the new wing was arranged for the temporary accommodation of 27 imbeciles who arrived from Orillia on July 27th. In September 1882, 75 imbeciles were transferred from Hamilton to Orillia.

Mimico Asylum (New Toronto)

In 1890, carrying into effect the views of leading philanthropists, the government decided to try the experiment of equipping a new asylum solely for the chronic insane, who were to be transferred to it from other provincial asylums.

Mimico was considered to be central and a suitable location and it was to be known as the "Mimico Branch Asylum" and was to be directed from the Toronto Asylum. It was so conducted from its opening on January 20, 1890, until November 1894. At the latter date, copying the example set by the State of New York, it was decided to be neither wise nor just that a large body of the insane should be branded as hopelessly incurable and herded by themselves. The Mimico branch was therefore transformed into an independent institution, serving chiefly northern Ontario.

Brockville Asylum

The Brockville Asylum was designed to serve the needs of the nine most easterly counties of Ontario. The construction of the first building was begun in 1892 and the institution was opened December 27, 1894, by the transfer of 73 patients from Mimico.

Cobourg Asylum

The Cobourg Asylum was created by the purchase and conversion of Victoria College, the academic headquarters of the Methodist denomination prior to federation with Toronto University. It was opened on January 14, 1902, by the transfer of 31 women patients from each of Mimico and London.

Penetanguishene Asylum

An Order-in-Council in 1904 authorized the transformation of the Reformatory for Boys at Penetanguishene into an asylum for the insane. It was opened on August 16, 1904, by the transfer of 50 patients from the Mimico Asylum.

Orillia Asylum

The Orillia Asylum was originally located on a plot of 13 acres near the northern boundary of the town of Orillia, and on the west shore of Lake Couchiching, now Couchiching Park. The building was intended for a summer hotel but was left unfinished, and was purchased in 1859 by the Province of Canada and fitted up as a branch asylum in connection with the Toronto Asylum.

Opened in 1861 it was vacated by the insane in 1870 and in 1876 was again fitted up, with some additions to accommodate 150 idiots. On September 25, 1876, 35 idiots were transferred to Orillia from the idiot department of the London Asylum together with some urgent cases from gaols, bringing the total to 44.

To relieve the rapid congestion some patients were sent to Hamilton until the vacant "Queens Hotel" in Orillia was leased and the patients returned from Hamilton.

Overcrowding continued. In 1885 the government purchased 150 acres on the shore of Lake Simcoe and about a mile outside Orillia for the erection of a new establishment. In November 1887, boys from the former Queens Hotel were admitted and in February 1888 girls were admitted from the original structure plus about 30 who had been sent to the Kingston Asylum.

In 1888 the first Canadian training school for feeble-minded children was started with a teaching staff of eight teachers. This was started in the original building which was finally vacated on April 1, 1891.

Woodstock Hospital for Epileptics

Epileptic patients were admitted to the Woodstock Hospital on April 22, 1906.

In 1939, the care of the tuberculous mentally ill was centralized in the Ontario Hospital, Woodstock. This was a further step in a program of tuberculosis control started in 1930, which has been recognized in other countries as possibly the most advanced in the world.

Toronto Psychiatric Hospital

The Toronto Psychiatric Hospital commenced under the provisions of the Reception Hospital Act on July 9, 1914, in part of the old Toronto General Hospital on Spruce Street, which had been vacated. The present building opened on December 7, 1925, as the result of a tri-partite agreement among the Provincial Secretary's Department, the City of Toronto, and the University of Toronto.

More recently, Ontario Mental Hospitals and Hospital Schools have been opened as follows:

(continued on page 102)

What Do Statistics Show?

A. H. Sellers,
M.D., D.P.H.,
Toronto, Ont.

WHILE the true incidence and prevalence of mental illness and defect are not known, available data provide a good measure of the problem, particularly in relation to the requirements for hospital and supervisory care. In addition the first-admission rate to mental hospitals is a useful guide to the incidence of mental illness and its general trend in the population.

Available statistical data on mental illness are those of "disabling" mental illness, namely those relating to patients treated in mental hospitals and in psychiatric units of public hospitals and those attending mental health clinics and psychiatric out-patient departments.

The statistical data used in this article were derived largely from the Annual Reports of the Mental Health Division, Ontario Department of Health, and relate to approximately 90 per cent of the total mental-hospital patient volume in Ontario.

Patient Population

On January 1, 1959, there were 24,507 patients under the supervision of sixteen Ontario mental hospitals and hospital schools. This is a case-rate of 422 per 100,000 population, equivalent to one person in every 237 in the whole population. Included in the total number of patients under care were 952 patients in approved homes. On the average during the preceding year approximately 10 per cent of patients were on probation.

In addition, there were 297 patients in psychiatric wards of public general hospitals on January 1, 1959, and 4,636 active cases on the books of out-patient psychiatric departments or mental health clinics reporting regularly to the department; this gives a total of 29,440 patients under treatment or 5.0 per 1,000 population.

The author is Director of the Division of Medical Statistics, Ontario Department of Health.

The absolute number of patients in Ontario mental hospitals and hospital schools, both in residence and on the books, has increased persistently throughout the past forty years—almost tripling in this time. The number of patients in hospital at the end of the year expressed per 100,000 population, however, remains much the same as it has been since 1937, and the total hospital case load (patients on the books per 100,000 population) has not changed materially since 1950—the increase in patient load being matched by the increase in the total population of the province. This indicates that population increase, increase in life expectancy, possibly more general recognition of mental disorders, and growth in hospital facilities, largely, if not entirely, account for the observed increase in the number of patients hospitalized.

The pattern of care, however, has changed. More patients are receiving care in organized psychiatric services, in-patient or out-patient and the turnover of patients in mental hospitals has increased, owing largely to modern therapy—the average stay is shorter though the numbers of relapses and readmissions have increased. With modest changes in total bed capacity, this has made possible the treatment, though not necessarily the cure, of a much larger number of patients.

The Current Case Load

There are two major diagnosis groups in Ontario's mental hospitals—the psychotic patients comprising 65 per cent of the total and the non-psychotic patients (largely mental defectives) 35 per cent.

Schizophrenic patients comprised 37.7 per cent of the total mental hospital case load as at January 1, 1959; mental defective patients without psychosis or epilepsy comprised 27.6 per cent (total mental defective patients 34.6 per cent); senile patients 7.2 per cent; and all other diagnosis categories 27.5 per cent.

How long have the patients now in hospital been on the books? At the end of 1958, more than one in every six patients (17.4 per cent) had been on the books for 20 years or more, and almost one in five (18.8 per cent) for 10 to 19 years. Over one-half (54.2 per cent) of the total patient case load had been on the books for five years or more.

Of the patients with schizophrenic disorders, 61.1 per cent had been on the books for five years or more; for all other psychoses the figure was 42.1 per cent; for mental deficiency the figure was 61.6 per cent; and for all other patients without psychosis 37.2 per cent.

Of all patients who had been on the books for 20 years or more, 53.3 per cent were patients with schizophrenic disorders. Patients with mental deficiency without psychosis contributed 25.0 per cent; if patients with psychosis or with epilepsy in whom mental deficiency is a significant feature are included, this figure becomes 32.7 per cent.

Age Variations

Age variations in the trend in the in-patient case rates are noteworthy. While the total resident-patient rate has not changed materially in the past 20 years, the rate at ages 65 and over has risen substantially and persistently, and now approximates almost 1,000 patients per 100,000 persons alive at these ages or one per cent.

Meanwhile the rates at ages 25-34, 35-44, and 45-54 have declined: those for 25-34 from 1953, those for 35-44 from 1941, and those for 45-54 from 1949. The rates at ages 55-64 years have tended to move upward since 1948. The rate for patients under age 15 has almost doubled since 1949 (54.2 at end of 1949 vs 97.4 at end of 1958), a reflection of the very substantial increase in recent years in the hospital facilities available for mental defectives (1949—1,800 beds, 1958—4,138 beds).

First Admissions and Readmissions

During the calendar year 1958, a total of 7,285 patients were admitted to Ontario's mental hospitals and hospital schools for treatment: of this number 4,936 were

first admissions and 2,349 were readmissions, rates of 85 and 41 per 100,000 population respectively. Readmissions thus accounted for 32 per cent of the total admissions. The greatest number of readmissions occurred in the middle age groups: two-thirds of the patients readmitted to Ontario Hospitals during 1958 were in the age group 25-54 years.

During the past ten years the total admissions to mental hospitals have risen by 84 per cent, and the admission rate per 100,000 population has increased from about 90 to 125. First admissions have increased from 3,032 or 71 per 100,000 in 1948 to 4,936 or 85 per 100,000 in 1958, an increase in the rate of more than 20 per cent. Readmissions have increased from 928 or 22 per 100,000 in 1948 to 2,349 or 40 per 100,000 in 1958, an increase in the rate of more than 82 per cent.

The increase in readmissions in the past ten years has been shared by all age groups; the absolute numbers have more than doubled in every age group since 1949. The first-admission rates were higher at all ages in 1958 than they were ten years ago, but this increase is greatest among the very young and the old. The rate for patients 65 years of age and over has almost doubled since 1941.

The highest readmission rate is in the schizophrenic disorder group, which accounted for more than one-third of the readmissions during the year 1958. Nearly 60 per cent of the number of readmissions during 1958 were patients with schizophrenic disorders or manic-depressive reaction; the remainder of the readmissions are distributed fairly evenly over the other diagnosis groups.

Type of Admission

The great majority of first admissions are certificated patients; these comprised 74.4 per cent of all new admissions during 1958 compared with 80.6 per cent in 1951. Voluntary admissions have increased in recent years, from 3.0 per cent of all new admissions in 1950 to 8.8 per cent in 1958. Patients admitted on Order of Magistrate comprised 10.8 per cent compared with 5.9 per cent in 1950.

Discharges and Deaths

In 1958, a total of 5,383 patients were discharged from hospital, a figure more than twice that for 1950, the discharge rate reaching an all-time high at 93 per 100,000 population or 74 per 100 patients admitted, and 172 per 1,000 patients treated. Most age groups have shared in this development. The sharpest increases in the discharge rates per 1,000 under treatment have been those at ages 25-54 years.

Deaths totalled 1,370 in 1958, a rate of 49 per 1,000 patients treated or 19 per 100 admitted. The crude death rate at all ages has been pretty stable in recent years. Over the past ten years there has been a noteworthy decline in mortality in most age groups, especially at ages 25-54 years.

Older Patients

The care of patients in the older groups has become a matter of significant importance. More than one-fifth of the patients now in Ontario mental hospitals are 65 years of age and over. The proportion of older patients has increased substantially over the past ten years from 17.0 per cent of the total case load at the end of 1949 to 21.6 per cent at the end of 1958.

The older patients in our mental hospitals are of two types; those admitted later in life with a mental disorder due to senile changes, and those admitted at an earlier age, largely patients with schizophrenia or other functional psychosis, who grew old in the hospital.

Two-thirds of the mental-hospital population is comprised of psychotic patients. Over 90 per cent of patients 65 years and over fall into this category; the senile psychoses including psychoses with cerebral arteriosclerosis ("diseases of the senium") comprise slightly more than one-third of the total (7.2 per cent of all patients).

There has been very little change in the proportion of all first admissions who are 65 years of age and over; the figure has remained much the same (21 to 22 per cent or one in every five patients) throughout the past ten years. For readmissions the picture is somewhat different. Readmissions age 65 and over constitute only about 12 per cent of readmissions at all ages (compared with 21 to 22 per cent for first admissions); they comprise about 20 per cent of the 1,303 total admissions at 65 years of age and over.

Discharges (alive) at ages 65 years of age and over constitute about 10 per cent of discharges at all ages. Deaths among patients age 65 and over now comprise about 75 per cent of the deaths at all ages in Ontario mental hospitals. Two-thirds of the separations from hospital among patients aged 65 years and over are by death. For the senile-psychosis group the figure is 82 per cent.

Expectation of Mental Disorder

Expectations of admission to an Ontario mental hospital or hospital school have recently been prepared, based on the first-admission rates by sex and age for the three-year period 1955-1957*. These data suggest that 6.7 per cent of all males born in Ontario, or one in fifteen, may be expected to require admission to a mental institution at some time during their lives. Of all newborn girls, 7.3 per cent, or one in every fourteen, may require admission. At age 25, the figures are 5.6 per cent for males and 6.5 per

(concluded on page 92)

Ontario Hospital, Brockville

**The Expectation of Admission to an Ontario Mental Hospital, Sloman, Joan G. and Sellers, A. H., Division of Medical Statistics, Ontario Department of Health, March, 1959.*

The Changing Mental Hospital

A. Miller, M.D.
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THE conception of the hospital and its place in human affairs has been subject to considerable change and modification throughout a relatively short span of history. This situation can be explained fairly readily on the basis of rapid scientific and technological developments and social changes, particularly over the better part of the last century. The result of this, however, is best appreciated when seen through the eyes of the layman and particularly the sick person. Instead of the attitude of horror and fearful apprehension that was associated with the thought of hospital during and before the nineteenth century, today man considers the hospital as a special centre promising relief from suffering, cure of disease, comfort and understanding, and protection from harm. It is assumed that this attitude on the part of the patient which accepts the hospital as a place of help has therapeutic implications.

Changing Concepts of Mental Care

The mental hospital, like all other hospitals, has moved through periods of change in the last two centuries and this change has gathered rather considerable momentum particularly in the past two or three decades. A tremendous literature has appeared over this period reporting important developments in the philosophy, conceptual framework and operational organization of the mental hospital. In this report, an attempt will be made to review the changing trend and to describe the current conception of the mental hospital.

Institutions ministering to the mentally ill have experienced delays (compared to other institutions concerned with treatment) in reaching the status of hospital as a place of healing. There are probably two reasons for this, one rooted in the past attitude of society toward mental illness, dominated largely by the superstitious and mystical beliefs of the time and, the other, related to the relative slowness in the development of scientific method in the field of mental phenomena and human behaviour. The former point was reflected by the kind of treatment meted out to the mentally disordered up to the end of the eighteenth century. For the most part this consisted of brutal and sadistic incarceration of the unhappy victims. Approaches initiated by Pinel of France, and in the York Retreat in England, led to a change in the picture and the appearance of medical treatment for the mentally disordered.

During the ensuing years—extending into the twentieth century—there was fairly rapid growth of the concept of decent, considerate and humane treatment for the mentally ill. Large institutions sprang up rapidly in the United States, Canada and Europe, particularly during the mid-nineteenth century, largely based on the concept that the provision of humane treatment of the mentally ill was essential. This development, in great part, emerged as a result of the dedicated efforts of people like Dorothea Dix, Isaac Ray and Benjamin Rush. This phase of hospital psychiatry has been called the era of "moral treatment"—and it was a great step forward. However, its main focus was on institutional care, and although providing care and shelter, and reasonable human contact, the approach expressed the current view that the person designated as mentally disordered required removal from society. The institutions erected were massive, usually located in isolated areas removed from the community, drab in the general decor and providing rather low standards of living conditions.

The growth of psychiatry, particularly over the past seventy years, has brought important and significant insights for the field of medicine. It has focussed attention on the relationship between emotional problems and human disability. It has directed attention to the dynamics of human behaviour and to the implications of psychopathology in everyday living, and has brought the problem of mental disorder into its proper perspective as a medical problem which could be investigated, understood, researched and treated. This acceptance of mental disorder as an illness was the important milestone which shaped the characteristics of present day trends in psychiatric treatment. Early in this development the therapeutic emphasis was on altering psychopathology, either by the utilization of psychotherapeutic approaches or by administering a variety of somatic therapies, such as electrotherapy, insulin therapy, neurosurgical treatment or more recently, drug therapy. These techniques and their proper administration were and still are of major importance in the therapeutic program, but not until it was clearly recognized that the hospital itself was a therapeutic force, was it possible to formulate a total program of treatment. This conception of the hospital as a therapeutic centre or therapeutic force has been clearly described by Maxwell Jones in his book[1]*, in which he refers to the hospital as a therapeutic community. Jones regards the therapeutic community as one in which the whole of the time spent in hospital, including all that happens there, is assumed to contain elements of therapeutic value. Thus, the therapeutic community is really a point of view, one which seeks to integrate every detail of hospital life into a continuous integrated program of treatment. Viewed this way, everything about the hospital becomes important—that is, the aesthetic qualities of the hospital, the architectural characteristics, its size, its ward formation, its unit structure, its living facilities, the quality of the diagnostic facilities, the quality of food and the way it is served, the social organization of the hospital (which includes the selection of staff and the attitudes of staff),

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For references see page 95.

the behaviour of all personnel and the organization of programs.

It is obvious that the basic assumption underlying this point of view becomes the spring board toward the approaches required for the most effective use of the hospital in the treatment of mental disorder. It should be mentioned that a great number of excellent studies have been carried out around and in relationship to this area. Notable are the sociological study conducted by Stanton and Schwartz and reported in their book —*The Mental Hospital*[2], and the Russell Sage project described by Greenblatt, York and Brown in the book *From Custodial to Therapeutic Care in Mental Hospitals*[3], and others. Numerous reports have appeared from the United States, Canada and Europe, describing developments on many levels of hospital organization planning and programing which have contributed to the improvement in patient care and therapeutic response. This work has led to the crystallization of the present concept of the hospital as a therapeutic centre and focussed attention on the organizational framework of the hospital as being synonymous with the notion of therapeutic milieu. As a consequence, many levels of this problem have been studied in detailed fashion and in this article we will focus on a number of levels which have been considered important as well as outlining the general consensus of opinion which provides the broad framework for modern planning and action.

Architectural Structure of the Mental Hospital

A good deal of attention has been directed toward the size and the architectural structure of the modern mental hospital. Many hospital psychiatrists have expressed the opinion that massive hospitals with many thousands of beds are now outmoded. It has been recognized that this type of hospital makes it almost impossible to organize and integrate therapeutic programs in any effective manner. It also makes it virtually impossible for the head of the hospital and the medical staff to study patients satisfactorily or direct treatment effectively. To a large extent, this problem has been created by large admission rates, overcrowding and inadequate facilities, but it has been accentuated by distances to be covered and the inevitably poor quality of communication. The majority of hospital psychiatrists would favour a hospital preferably no larger than five hundred beds, and certainly not more than seven hundred and fifty beds. But the size of the hospital is not the only important factor in the structure of the new hospital. The organization of the ward units has become an important issue and again the opinions generally accepted would be that the ward units should be relatively small, probably consisting of thirty to forty beds, and that the unit should be so constructed that the patients would have satisfactory facilities for social, vocational and recreational activities. It has often been forgotten that the great difference between the psychiatric patient and the patient suffering from physical illness is that the former is for the most part ambulatory and as a consequence this forces a quite different conception of what is required in architectural planning and patient facilities. This must be considered as an essential part of the planning program; and indeed, facilities which restrict or deny opportunities for social, recreational, avocational, and vocational, and indeed all normal human activities, would represent a serious blow to any therapeutic program. Further, it must not be forgotten that the living facilities for all patients have to meet an acceptable standard of comfort and convenience; this directs attention to adequate toilet facilities, bathing facilities, seating facilities in dining rooms, closet and locker space, furniture and appliances, and so on.

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Plans for mental hospitals have sometimes failed to keep in mind the fact that mental hospitals as now organized, deal with three major groups of patients:

1. The acute psychiatric patient. This refers usually to recent admissions who require investigation, diagnostic assessment and plan of treatment.

2. The long term or relatively long term patients who are ambulatory and are able to function on a so called convalescent ward; these are patients for whom activity programs, milieu therapy (socializing programs) and individual therapy are required—with major emphasis on social therapy.

3. The chronic patients who basically require a good deal of nursing care, shelter and medical care with sufficient social and recreational programs to keep them pleasantly occupied.

As long as these three major groups of patients are housed in the mental hospital, the planning of facilities would have to take into account the special needs of these patients, and provide the living area and the ward facilities, and the special arrangements to deal with these kinds of problems. Fundamentally, the basic requirements of a modern hospital would of course be required for proper medical service. It should include all modern facilities required for the proper investigation of the sick person including laboratory facilities, radiological facilities, electroencephalographic equipment along with facilities for the treatment of physical problems, requir-

ing therefore surgical, dental, physiotherapeutic and other facilities.

In a mental hospital, of course, it would also be necessary to make provision for special departments required for the diagnostic and treatment program. These would include occupational therapy, psychology, and social service departments. Thus, the modern mental hospital is envisaged as a setting providing the necessary facilities allowing adequate opportunity for proper personal, social, and vocation experience.

The Social Organization of the Hospital

The concept of therapeutic milieu makes rather special reference to the importance of the philosophy and the attitudes of hospital personnel. From the point of view of philosophy, the attitude of the senior staff with respect to the function of the hospital is an important factor in determining the atmosphere which prevails throughout the whole hospital. Further, it has been emphasized that all the staff in the hospital are part of the social milieu, and that everyone to some extent contributes to the therapeutic effect of the hospital; this includes the non-professional as well as the professional staff. It is assumed that properly qualified professional staff in adequate numbers are essential to the proper implementation of a comprehensive program of treatment for the patients. This staff includes psychiatrists, psychiatric nurses, social workers, psychologists, the occupational therapists, the technicians, the dietitian, and special personnel such as recreational instructors, social program instructors and physiotherapists, and frequently chaplains. The ratio of the professional staff to patients ideally should be in a range which is therapeutically suitable, but generally it is felt that as long as there are sufficient staff to meet the program needs of the hospital this would provide an adequate staff-patient ratio. It has been frequently noted that the attitude of staff, their orientation towards colleagues and patients, the capacity for acquiring new insights towards the understanding of patients—and the utilization of relationship techniques have major impact on the therapeutic process. Many of the staff who deal with patients do not have any special training prior to employment. And so it is necessary to orient and instruct members of the staff along the lines needed to relate themselves most effectively to the treatment program. It is probably accurate to state that the staff who know their job, who have clear insight into the potential problems, and who use their skills effectively will provide a therapeutic force which will have great significance to the therapeutic milieu.

Admission Procedures in a Mental Hospital

Along with the newer conceptions of the mental hospital, there has been growing dissatisfaction with the legislative aspects governing the admission, maintenance and discharge of patients from mental hospital. A definite trend has emerged in recent years toward encouraging and facilitating admissions to hospital on a voluntary basis; also there has been a good deal of thinking directed toward changing present legislation so that the legal and admission procedures will fit in with the notions of what is really beneficial for all concerned. This would be designed to remove the obstacles and difficulties which have been encountered up to date in facilitating hospital treatment for a patient in a community and to remove the stigma of psychiatric treatment.

The Open Door Policy

In the past, most wards in mental hospitals were closed. This locked door atmosphere tended to create a feeling of incarceration and fostered resentment and hostility in individuals who already suffered from a sense of isolation and rejection. In recent years the trend toward opening the ward doors has developed with amazing speed. In large part this reflected the opinion that a great number of the patients in mental hospitals could function quite satisfactorily on open wards. It is true that there is always a small percentage of the patient population which requires special security measures, but these usually represent such a small minority that many mental hospitals have opened doors and provided a setting where the patient has greater freedom of action and can develop some interaction with the outside world. But the development of the open door policy has brought even greater attention to the necessity of developing programs including a wide variety of activities with social, recreational and avocational goals—organized on a scale broad enough to meet the needs of all types of patients. As noted previously, the organization and orientation of staff trained to direct and participate in such programs is obviously essential. But basically, these developments have significance mainly in their contribution to the growth of the hospital community. This is seen in the establishment of group activities—patient government, the setting up of a hospital newspaper, the organization of special programs having to do with drama and sports activities, et cetera. All of these tend to create the cultural climate of the hospital and bring into being those elements approximating the cultural setting of the society in which the hospital exists.

Professional Relationships

It is quite clear that the mental hospital today is not only concerned with developing a better program of treatment for mental disorders, but also in eliminating the professional isolation which has persisted too long. This trend has been reflected in the development of a closer liaison between the field of psychiatry and other branches of medicine, and this has led to a closer liaison between the mental hospital and general hospitals in the community, and the freer exchange of opinions between those working specifically in the field of psychiatry and the medical profession. The sharing of medical programs, the exchange of consultations, the closer collaboration on projects which have a joint interest, the utilization of public health facilities in relationship to the problems of the mental hospital, and the closer liaison of the general practitioner with the hospital staff to solve the problem of the patient, have been of importance in the creation of useful professional relationships. This development has tended to bring the mental hospital into a climate which encourages and facilitates free exchange of scientific and professional interests. But these have not been the only ways of establishing and developing this trend. Mental hospitals are engaged in a program of psychiatric teaching and training for under-graduate and post-graduate medical students, for social work students, and for students from faculties of psychology, occupational therapy and physiotherapy, education and nursing. This has not only led to greater familiarity with the principles and practices of psychiatry for the

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Modern Concepts of Treatment

1. Individual Therapy

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FROM TIME immemorial humans in emotional distress have tended to turn to other humans for help and guidance. The doctor and the psychiatrist in particular are among those from whom the individual seeks help. Whatever the type of psychiatric illness, the frame of reference or the specialized techniques that may be involved in treating the patient, the intimate, complex, patient-doctor relationship remains the central core of effective therapy. It is out of this relationship that spring the forces of psychotherapy. This term is not easy to define and it is unlikely that any one definition will satisfy the criteria of all psychiatrists. Here are two definitions that may meet the approval of the majority: "Psychotherapy is the scientifically directed influence of the doctor on the mind of the patient in promoting health."[1]* "Psychotherapy is a form of treatment for problems of an emotional nature in which a trained person deliberately establishes a professional relationship with a patient with the object of removing, modifying or retarding existing symptoms, of mediating disturbed patterns of behaviour, and of promoting positive growth and development."[2]

Psychotherapeutic Approaches

It would be presumptuous on my part to attempt a classification and description of the many schools and techniques of psychotherapy. However one might consider profitably two fundamental kinds of psychotherapeutic approach, one which is primarily exploratory and one which is primarily supportive. In either case there are certain basic assumptions. It is reasoned that psychological forces, for the most part outside the awareness of the individual, are responsible for the patient's state of anxiety or depression or for the disordered thinking, feeling and behaviour of the schizophrenic illness. Just as in physical illness the doctor works on the principle that the symptoms only make sense in terms of underlying disordered physiological functioning, so in the realm of psychological illness it is assumed that psychiatric symptoms do not "just happen" but are related to the interplay of complex psychological forces operating within the psyche and in response to the social stresses of living. It follows, therefore, that the therapist should be trained in the field of psychodynamics in order to understand the likely forces at work, appreciate the significance of the resultant defense mechanisms and treat the patient intelligently.

With exploratory techniques the psychiatrist is attempting to help the patient understand underlying conflicts on the principle that with increasing ventilation and insight there will be a concomitant emotional growth and incidentally a lessening of symptoms and disability. Exploratory techniques are largely influenced by the psychoanalytic schools and the most ambitious goals of altering fundamental character structure are attempted in psychoanalytic therapy.

All types of psychotherapy involve support of some kind. "The very relationship with the therapist provides it, whatever other implicit or explicit elements of support may be also present."[3] In supportive therapy, the therapist is intentionally employing measures to brace or re-establish the individual's defense mechanisms. It may be obvious that the patient's inner strengths are not sufficient for him to tolerate the anxieties and disintegration that might result from a primarily exploratory approach. Lesser goals may be indicated, either strictly supportive therapy or supportive plus a moderate degree of exploration. Supportive measures also may be indicated at crucial stages of exploratory techniques when there are signs of impending emotional decompensation. Supportive techniques include reassurance, advice, suggestion, prescription of daily activities, development of related but new defense mechanisms, the encouragement to invest interest and effort in cultivating new sublimation activities and aiding the patient to more satisfactory social adjustments. Supportive therapy also implies the employment of external supports such as those afforded by admission to hospital, eliciting the help of a warm friend or relative, and the temporary reduction of environmental demands on the patient. Many patients, temporarily overwhelmed by inner and outer pressures, when helped by supportive measures rapidly improve with the resurgence of inner strengths and reconstitution of habitual defense mechanisms. Supportive therapy has been considered "the poor relation" of the psychotherapies and although the goals are very limited compar

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**For references, see bibliography on page 68.*

to those of exploratory techniques, it can be very effective in selected cases and may require the utmost in skill and resourcefulness on the part of the therapist.

Psychotherapy plays its most significant rôle in the treatment of the psychoneuroses, mild and moderately severe depressions, and incipient schizophrenic reactions. Most psychiatrists, however, consider psychotherapy the cornerstone of all psychiatric treatment and indeed "an essential element of all medical practice".[4]

Some would say that psychotherapists are born not made; that psychotherapy is more an art than a science. The implication is that all that is necessary is a natural intuition plus experience. There may be a grain of truth in this point of view, but even in the arts, such as painting and music, intensive training in the skills and techniques of these fields is usually a necessary prerequisite for even the most gifted in order to develop into a superior painter or musician. The understanding and treatment of the complex human personality is surely no less demanding a profession. There is need for continuing research into the dynamics involved in the patient-therapist relationship if we are to learn further about the forces that make for change.

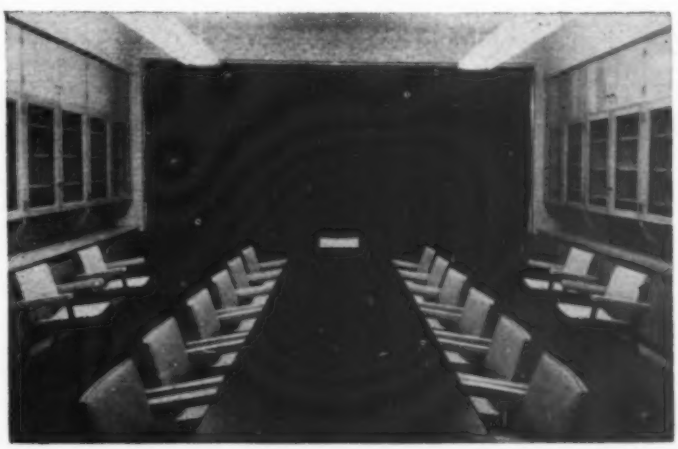
Somatic Aspects

If one is to give more than token acknowledgement to the concept of total approach to the understanding of personality functioning, it is necessary to attempt to incorporate the somatic aspects into a working conceptual framework. In the words of Gerty,[4] in reference to the attitude of our colleagues in other branches of medicine, "Part of the resistance to the acceptance of psychotherapy and to the grounds upon which it rests has been a too theoretical exposition of these grounds, often with unnecessarily unfamiliar terminology and much reference to mythology. Psychopathology, psychogenesis, psychodynamics and psychotherapy are things not detached from the living physical man. While I feel safe in assuming that there is no physical disease without its mental and emotional components, I am still safer in saying that no disembodied psyche ever came into my office." It is difficult to conceive of thinking, feeling and acting in the absence of tissues and cellular functioning. Recently there seems to be a definite swing toward the physical in the search for increased understanding and more effective treatment of mental illness. Indeed, Fleming[5] in his introduction to *Recent Progress in Psychiatry* puts it quite bluntly: "For some years it has become obvious that the basis of psychiatry is largely on physiology and biochemistry, together with a wide knowledge of the anatomy of the brain." The majority of psychiatrists no doubt accept the importance of these sciences to psychiatry but might have some reservations especially regarding the word "largely". In any case, after a long lag period, during which isolated but fundamental facts have been painstakingly established, neurochemistry and neurophysiology now are moving rapidly. Preceding these recent rapid advances and running concurrently with them has been the introduction of a host of empirical physical treatments, only a few of which are still being employed and considered of value by a large segment of psychiatry.

Treatments

Electroshock therapy is used extensively especially in the treatment of depressive illnesses, producing its most beneficial effects in those depressions that are largely endogenous in nature. It is employed also in the treatment of schizophrenic disorders either alone or in conjunction with insulin coma therapy, the acute catatonic and paranoid reactions responding best. There have been a number of theories, both physiological and psychological, attempting to explain the mode of action of electroshock therapy but no one theory has been considered entirely satisfactory. Many psychiatrists perceive electroshock therapy and therapeutic physical agents in general as only one aspect of total treatment. They consider it of greater importance to attempt the understanding and treatment of the whole person, an integrate of forces operating in a social *milieu*. A sizeable proportion of practising psychiatrists employ electroconvulsive therapy only under very special circumstances. They consider mental illnesses essentially in psychosocial terms, that physical treatment at the present time is nonspecific and symptomatic only in its effects. With this frame of reference, psychotherapy is basic for any major change in the personality. They, therefore, restrict shock treatment to patients who are too depressed to relate satisfactorily to the therapist, or when the depressed state is failing to respond to psychotherapy or worsening and if suicidal risk is too great. As the depressed mood lifts, psychotherapeutic measures are employed increasingly in order to deal with the underlying psychopathology.

Insulin coma therapy which is used in the treatment of schizophrenic illnesses is also an empirical method. In recent years it has been used much less, probably for a number of reasons. It is potentially dangerous compared with other forms of treatment and requires a well trained and vigilant team to administer it; many schizophrenic patients respond as well or better to tranquillizers; there is considerable doubt in the minds of psychiatrists that the results from insulin coma justify the procedure. However, some consider it to be the most useful form of somatic treatment for schizophrenia, with the best results with patients in their twenties, who have had pre-



Board Room

viously well integrated personalities, have had an acute onset, are displaying paranoid or catatonic features and have not been ill more than a year.

Ambulatory or sub-coma insulin is aimed at producing a mild or moderately deep hypoglycaemic state without loss of consciousness. It can be of considerable value in relieving severe anxiety symptoms especially if the patient is much underweight. The psychological rather than the strictly physiological effects of the procedure can be of major importance in the total therapy. This raises a whole area of psychological implications, both positive and negative, whenever a physical procedure or medication is administered. The meaning that it has for the patient usually can be understood only in terms of the underlying psychodynamics. More obvious mechanisms however are frequently in evidence, for example, the significance to the patient of receiving a "scientific" form of therapy or the feeling that the illness is at last being considered a socially acceptable disease beyond the personal responsibility of the self. These are but two possibilities that may confuse the task of assessing any specific physiological effect of therapy. Not the least of the complications is the alteration in the already complex patient-therapist relationship. Any or all of these psychological implications may be equally operative in the physical treatments of organic diseases which any observant intern may note on a medical or surgical ward.

Psychosurgery may be defined as surgical operation on the intact brain for the relief of mental symptoms. The usual procedure involves severance of the connection between the thalamus and frontal lobe. Even at the height of its employment, psychosurgery received a mixed reception from psychiatrists. Some of the reservations were moral and ethical in nature but there have been also strictly clinical concerns such as the risk of death, the possibility of the development of regressive symptoms and of epilepsy and, in general, the finality of a technique that is

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2. Activity Therapy

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THE modern concepts of treatment are composed of basic widely accepted concepts and concepts which are developing in the light of increasing scientific knowledge and the establishment of facts through experience. Perhaps the most significant of these basic concepts are those implied by such words and phrases as humane, human dignity, human rights, basic needs of man for activity, exercise, work, learning and recreation. This paper is concerned with man's basic need of activities to promote his growth and development, to aid in maintaining or regaining his health, and to contribute to his achievement of purposeful and gratifying living. Of these basic activity needs of man, the need for work is the greatest in amount and in importance. Modern concepts, particularly about treatment and rehabilitation, determine the principles and practices of treatment and rehabilitation services. These concepts determine the attitudes of us all—whether we be personnel, patient or the public—towards illness, injury and disability and towards treatment and rehabilitation. Let us look briefly at some of the most significant of these concepts.

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The ultimate purpose of treatment is to restore function and because of this, treatment and rehabilitation are inseparable. Mind and body are inseparable. Illness, disease or injury of a part affects the whole man. The whole man should be considered throughout treatment and rehabilitation. Re-establishment of function and socio-economic adjustment of the patient are vitally important to his welfare and to society. Function of the unaffected parts should be maintained whenever the disability permits. Latent aptitudes and abilities should be explored to compensate for residual disabilities. "Optimal restoration" acknowledges the factors of residual disability, limited attainable function, the realistic values of partial rehabilitation and the need for adjustment and readjustment. Ultimate partial restoration of function is worthwhile. As far as possible, the activities used for the purposes of treatment and rehabilitation should be realistically related to the work and the community to which the patient will be rehabilitated. Restoration of an individual to optimal socio-economic function involves many people and many processes—and the focal point is the patient. Treatment and rehabilitation processes are most effective when they are organized and co-ordinated like a team, with the patient as a participating member throughout, and when they include his family and the community at all appropriate times. Greater knowledge and understanding by all—personnel, patients and the public—of mental hygiene, of mental illness and mental retardation and of treatment and rehabilitation are essential for progress in the treatment and rehabilitation of persons with mental disabilities.

These are the concepts which underlie and guide the practices of modern treatment and rehabilitation services; and they are increasingly understood and accepted by patients and the public. They are applicable to all areas of disability, physical and mental and to all treatment and rehabilitation procedures, including activity therapy.

What is Activity Therapy?

The appearance of this term, activity therapy, is a welcome one indeed, as it makes it possible to collect and bring into focus the current group of therapies related to the activities commonly known as occupational therapy, work therapy, recreational therapy, social therapy, music therapy, art therapy, and so on. For the purposes of clarity, let us consider that

Table No. 1

Re: Changes in the past 75 years in the general population of Ontario and the population and number of Ontario Mental Hospitals.

	1883	1958	
General Population	1,923,000	5,803,000	
Mental Patients in Hospitals	2,825	20,178	
Admissions during the year	543	7,285	
	3,368	27,463	
Discharges	269	5,383	
Discharge rate approximately	8%	18%	
Patients occupied in hospital maintenance shops and services	1,479	7,711	
Proportion of resident current patient population	52%	38%	(approx.)
Number of mental institutions			
"Lunatic Asylums"	4		
"Idiot Asylums"	1		
Mental Hospitals		14	
Hospital Schools for Mental Defectives		2	
	5	16	

"activity" pertains to work training and recreational activities.

The main purposes for which these activities are used in psychiatry are:

1. The amelioration of specific symptoms and the re-establishment of lost or impaired function.

2. The maintenance of normal function in capabilities which are not affected.

3. The provision of normal activities to meet the basic needs of the patient.

4. The discovery, motivation, and development of latent abilities which may facilitate the rehabilitation of the patient.

5. The provision of sub-industrial training for the development and re-establishment of ability to participate in healthy, interpersonal relationships.

The picture today with regard to activity therapy is the result of many factors. The most significant of these include the increased scientific knowledge of mental disabilities and successful methods of treatment and rehabilitation; the bringing together of community and mental health services; and changes in our population, culture and economy.

With advances in the uses of psychotherapy, drugs, surgery, et cetera, vast numbers of hitherto inaccessible and unapproachable patients now can and should participate in activity therapy. In fact there is only the relatively small group of people of severely limited capabilities associated with old age, infirmity and gross mental defect who cannot participate in some worthwhile activity.

Early diagnosis and improved treatment services and facilities are also affecting this picture through prevention, early treatment and early rehabilitation. These are lessening residual disability and loss of living and working skills. Among the recent added facilities are specialized units for day care, for habitués, for emotionally disturbed children, et cetera; and expansion of all the existing treatment and rehabilitation services.

The bringing together of the community and the mental health services has started by opening the doors of the hospitals and by an extensive program of public education. Through these two main channels, knowledge is being presented to the people in the community which is effectively developing healthy attitudes toward and understanding of mental illness and retardation and treatment and rehabilitation. There is a rapidly increasing number of well-informed, interested people who can and do help both in the hospitals and in the community. Their present contribution is very valuable and their potential contribution is both tremendous and essential.

With regard to activity therapy in the hospitals, there is a great need for a broader and more dynamic use of trained and skilled citizens as advisors, as staff and as employers; and of work and training opportunities and facilities in the community for the rehabilitation of patients.

Changes in the community with regard to population, culture and economy are directly reflected in the mental hospital, since the patient population is a cross-section of the population the hospital serves. In Ontario there have been in the past 75 years very dramatic changes, from 1,923,000 to 5,803,000 in population, from a rural to an urban culture and from an agricultural and man-powered to an industrial and mechanized economy. Some interesting statistics and comparisons are presented in *table 1*.

Mechanization and industrialization are affecting similarly the occupation of people both in the community and in activity therapy in the mental hospitals. Much work is done by a few highly trained technicians operating mechanized equipment.

In our hospitals the suitability and value of patient participation in farm work is questioned. In this changing picture with mechanization, it is unrealistic economy-wise

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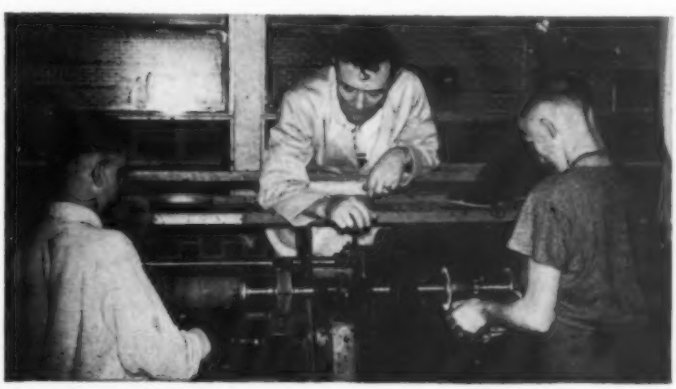

Vocational Training

Restoration to Community Living

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St. Thomas, Ontario.

MOST families will still put up with much peculiar behaviour, conversation, and maladjustment in a family group, before they bring themselves to believe that the member concerned is mentally ill and needs psychiatric care. This is usually because the changes are gradual, and the time comes when outsiders can see obvious symptoms which the family still rationalizes as eccentricity. Finally some acute situation develops and the patient is rushed to mental hospital.

The modern hospital is geared to begin suitable treatment as soon as possible, and also, it is so oriented that, beginning with admission, all treatments and attitudes of staff are designed with the purpose of helping the patient to make a successful adjustment in his home community when the acute phase of his illness is over. The stay in hospital is only a very tiny part of the illness, which has developed over months and years, and the achievement of a satisfying adjustment also takes a long time—after the hospital period is over. In other words, the hospital tries to put the patient on the right track, and tries to explain to the family why this illness has occurred. Sometimes, certain family attitudes can be altered, but often the short contacts make this an impossible task for the hospital staff.

Every hospital has made attempts to continue supporting the patient after leaving hospital, through its social service staff, or Mental Health Clinics—or by having the patient return to see his hospital physician at intervals (and this is increasing), but still many patients return to their essentially unchanged homes in which they "broke down" previously, and all contact with the hospital is lost. One of the main reasons is the traditional isolation of the mental hospital—in our case, having the largest centre of population over 100 miles away. This discourages visiting while the patient is in hospital, as well as contact during convalescence at home.

Dr. Cleland is the superintendent at the Ontario Hospital, St. Thomas, Ont.

**For references see page 70.*

Adjustment to the Community

Obviously, the best solution is to have some respected person in the home community who has some authority, who is familiar with the social structure and the social resources of that community, and who is acceptable to the family physician, to act as a counsellor and friend to the convalescent patient. We feel that the public health nurse can best meet all these requirements. We were intensely gratified to find that the public health nurse felt the same way. She had, many times, visited homes, and learned that some family member was in mental hospital, and sometimes was at a loss to know what attitude to take, or how to adjust her own feelings to the situation. We have all grown up with prejudices regarding mental sickness — that these are inferior people, that they are being punished by God, or possibly that they are possessed by devils — ideas which we find to be utterly untrue, and the result of ignorance.

The medical officers of health, too, were beginning to feel that the next problems of public health were the chronic diseases, accidents, and mental disease[1*]. When the number of hospital beds was taken into consideration, it appeared that mental disease was the largest field. The lack of a public health method of approach was the stumbling-block, since all methods employed at the moment were in the nature of treating individual patients, with little indication of how to treat a community to lessen or prevent mental breakdowns. However, a start must be made somewhere, and about two and a half years ago, we had a three-day meeting with senior public health personnel in our area. This was designed to familiarize the group with common symptom complexes, with hospital treatment, and with the present available methods of follow-up; and to discuss how they thought they could best help these patients. A program was worked out in which the patient, his family, his family physician, the public health department, and the hospital, were all involved. The referral system agreed on was as follows: The day after admission of a patient, a letter is sent to his family physician, advising him that we can arrange to have a public health nurse visit the family and the patient when he returns home, and asking the physician to let us know if he does not wish this service. In

two weeks, a preliminary report and a referral form are sent to the medical officer of health, and the family physician. Here, we ask for specific information required for diagnosis or for rehabilitation plans. If we feel that a home visit would serve no useful purpose, this is also indicated on the form. The next document to go out is the conference report—to the family physician and the medical officer of health. Lastly, when the patient goes home, the "follow-up" form goes to the family physician and the medical officer of health, listing treatment given, prognosis, and our recommendations. We also ask that the public health nurse send a copy of all correspondence she has with the hospital to the family physician, to keep him informed.

After two years' experience, we have found that one in three of our patients can benefit by public health nurse visits. Many of these will require one visit only—others will need regular visits over a period of months. It is also interesting that the nurses have already known about one third of the families previous to the illness. The nurses find that they have a broader understanding of their patients, and have gradually found that often they can do a great deal for certain patients by being a sympathetic listener. The aim of medical care is as true in psychiatry as in any other branch of medicine: "to cure sometimes, to relieve often, to comfort always."

Our plan for follow-up care, as described above, requires considerable effort at the hospital. A senior social worker acts as liaison officer between the public health personnel and the hospital, prepares the forms and reports mentioned with the help of the hospital physician, and personally visits all the centres involved on a monthly basis. Occasionally we will get reports from relatives that a patient, who has been at home on six months' probation, is well and should be discharged. In the same mail, there may be a report from the public health nurse that the patient is not well at all and she raises the question as to whether he should return to hospital for further treatment. Incidentally, we have dropped the idea altogether that every effort should be made to keep the patient at home despite his condition—we now feel that a short-term hospital stay may often be just sufficient for him to avoid another breakdown.

Orientation Course for Nurses

The orientation course for nurses is a three-day affair, which includes attendance at regular hospital diagnostic and treatment conferences, observation of our admitting department, of our treatment facilities and actual treatment procedures, specialized diagnostic tools, such as electroencephalography, and also our socialization facilities, occupational therapy, recreation, music, dance, and industrial therapies. There are informal talks on the common psychiatric syndromes, on psychiatric nursing, psychological tests, a review of the common tranquillizing drugs, an introduction to social case work, and the showing of some psychiatric training films, with discussions. There is also an opportunity to talk to various patients on our wards.

Approximately 125 persons have attended ten such courses—mostly public health nurses, but including social workers, industrial nurses, and other interested field workers. The groups have invariably been very enthusiastic. The public health nurses have expressed surprise on finding so many of our ward doors unlocked and the bars removed from the windows of our reception wards. Another comment concerns the number of patients participating in socializing therapies—such as the activity in the patients' lounge where both sexes mingle to read local papers, play cards, watch television, or listen to "Hi-Fi" recordings. All these things, of course, are designed to shorten the distance between hospital living and normal living, and to carry out the idea of a "therapeutic community".

Case Histories

Mrs. D.D., a 22 year old mother of two children, with limited physical exercise tolerance because of acute rheumatic fever in childhood, came voluntarily to hospital because she said her marriage was all mixed up. She was quite right—her husband had two wives, our patient and his mother. Doris was an immature, inadequate person, with impulsive tendencies, but in the hospital, she quickly lost her feeling of depression and confusion, and on leaving hospital six weeks later, she went to her mother's home. She was visited by the public health nurse and is now working at a local dairy bar. She still lives with her mother. Her husband comes and spends each night with her, but each morning gets up and goes to his mother's home for breakfast. Obviously, there is a great deal of social guidance and counselling to be done, but the public health nurse reports that our patient and her husband are planning to get away from their in-laws and in their own house very shortly.

Mrs. A.W., aged 32, became depressed when her husband disappeared with another woman. She was about five weeks in hospital. On her return home, the public health nurse assisted her in getting Mother's Allowance, and Angela is also working part-

(continued on page 70)

Easter Tea

Research in Mental Disorder

A. B. Stokes,
M.B., F.R.C.P.
Toronto, Ont.

THE history of psychiatry[1*], contrary to common belief, is rich in the names of great scientists. These, in their various times and places, bent the resources of their intellect to the very difficult problems which confronted them. If research may be regarded as the exploration of a territory of ignorance and the development of a community of knowledge, it was the terrain and climate of mental disorder that deterred advance, not the ardour or competences of the psychiatric voyagers.

Disturbance of the mind, understandably, was not a primary concern in the expansion of science. Indeed in the early stages of scientific development interest and solicitude were focussed on the validity of reason as a means of arriving at the truth of natural phenomena[2]. Reason, as an instrument of investigation, was directed objectively and any subjective drift was "corrected" meticulously. Rational enquiry therefore proceeded in relation to problems involving "things" which could be observed under controlled conditions. As far as mental disorder was concerned unreason and subjective experiencing seemed to hold sway and circumstances were not propitious for step by step development of proveable hypotheses.

General medicine was not affected in the same way. Disability at the organ level of physical functioning was amenable to the early application of the scientific method. Consequently great gains were made in the understanding and control of disease processes. By contrast psychiatry became isolated, rejected, and left behind in the great flood of intellectual and technical progress. At the same time, since the problems of insanity and emotional disturbance were ever present in society and something had to be done about them, the intellectual and technical isolation became associated with a physical isolation. Remote mental hospitals, organized for custodial care, became the working grounds of psychiatrist investigators.

It is not surprising, in the limiting circumstances of psychiatric enquiry, that classification of mental disturbance and empirical methods of control became the major objectives. Categorization of phenomena and "trial and error" methods of intervention have been ever present in all areas of research. The "discoveries", so made, are, however, much more quickly exploited and related to other advances in those fields where there is a parallel development of pure science. Practical inventiveness represents a successful jump in the dark: it attracts the illumination of scientific hypothesis which in turn reveals the possibilities of further jumps beyond. The mutual enhancement of empirical invention and pure science has been the success story of industrial development in the nineteenth and twentieth centuries[3]: in only little less degree does the same story apply to general medicine and the biological sciences[4].

Psychiatric empiricism has not been so fortunate: its jumps in the dark, although occasionally successful, have not been vigorously reinforced from a "ready" scientific position. Only in the past three or four decades have the biological sciences developed a readiness of application to the clinical problems of mental disorder: the psychological and social sciences have had a still shorter time in allied relationship. In short, psychiatry as a body of knowledge is poised for development like general medicine in the 1850's and industry in the 1750's[11].

Although it would be imprudent to appraise the 1960 position of psychiatry without recognizing its tardy maturation and technical backwardness, it would be an equal error to suppose that these qualifications are wholly disadvantageous. Scientific development and technological power have expanded, not in a vacuum, but in a human living scene. The advantages of the objective material approach to living are seen to be partly illusory and dehumanizing: a corrective recourse to the subjective, to an understanding of the nature of man, to his vulnerabilities, to the hazards of breakdown in living, is emergent[7]. Psychiatry, which has had to concern itself continuously with these problems over the period of the scientific revolution, finds itself suddenly responsible, eagerly bespoke, and actively supported. The new status, sometimes uneasily assumed, sometimes brashly flaunted, is attributable not only to the incorporation of scientific concepts from other fields into the psychiatric discipline, but also to the orderly development under its own auspices of a particular psychiatric resource—namely psychodynamics.

Psychodynamics is the study of human mental operations in inc-

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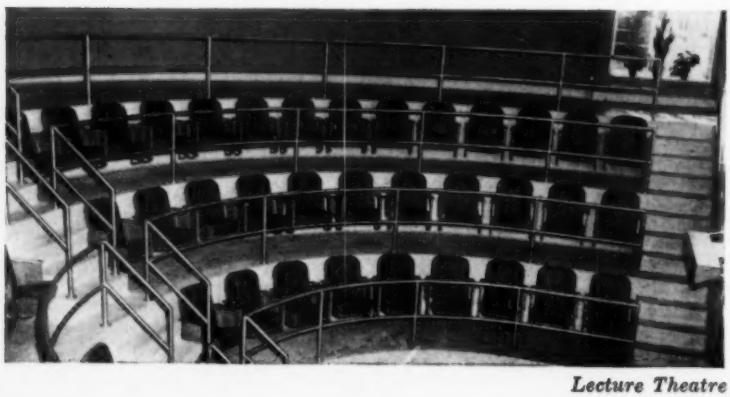
**For references see page 74.*



Lecture Theatre

tional terms. The study is concerned with the ways in which earlier life experiences, and the personal feelings about these experiences, are organized functionally to deal with the present needs of the individual, as he seeks to relate himself to his family, to his associates, to his job, and to his world of living. The ways in which these personal adaptations are made, in a varied, fluctuating, and capricious society, are multitudinous: objectives are often incompatible in terms of attainment so that choice or compromise is necessary. But the choice or compromise is rarely, if ever, wholly conscious. Some elements of the situation are always repressed and play their part in determining outcome at the unconscious level of mentation. Conflict, the psychic forces of repression, the unconscious, and the mechanisms of operation of unconscious urges are representative concepts in this area of enquiry[4]: the concepts have been derived inductively by studies of psychiatric illness[5].

Although psychodynamic theory has arisen by observations of mental phenomena, and to that extent originated outside the purview of the physical, the assumption must not be made that it has remained in isolation. In fact it has enriched somatic studies, made child development more understandable in psychological terms, and has given new meaning to social interplays. This has come about because the reality of emotion as an ingredient of every human activity has been recognized. Emotion, or feeling tone function, either hurtful or joyful, is a primary natural phenomenon: it cannot be easily differentiated qualitatively, much less measured directly, but its effects on organ function (stomach, bowel, heart, et cetera), on behavioural learning (*e.g.*, aggressive or submissive activities) and on social attitudes (authority, responsibility et cetera) are universally manifest[6]. Indeed psychodynamic theory, far from operating in isolation, is involved in every mode of approach to the problem of human disability. So much is this the case that the psychiatrist is obliged continuously to reaffirm his position as physician charged by tradition and training with the obligation of healing the sick. The reaffirmation is particularly necessary where researches into mental disorder are undertaken. Now, as opposed to 20 or 30 years ago, the difficulties are not those of restriction but of panoramic extension.

Particular Considerations

A review of the present research activities in the field of mental disorder may be simplified by outlining those known interrelationships which make up an individual human being engaged in the business of living.

Such a person, the product of conception, has *genetic endowment* reserves. These reserves are, on the whole, favourable to healthy living but perhaps never completely so: occasionally they are the main determinants of disease, but more often represent a deficit which, combined with faulty nurturing, precipitates a disability. On the basis of genetic endowment the pattern of the developing individual is decided by *molecular structure*, thence by cell structure, thence by organ structure so that a state of organ relationships comes into being, with the opportunities of *organ response* as an aspect of reactivity. The pattern of organ response is more or less unified under *endocrine control* and the endocrines in their turn are subject to a primitive nervous system which responds to the world around by *feeling tone* deemed more or less pleasurable or more or less painful. The feeling tone itself is continuously related to an incorporated personal life experience fixed in the *highest nervous system* as a consequence of sensory experience. The personal life experience gives individuality to the whole organization which assumes a more or less established *ego boundary*. Continuously, however, this individual relates to others in varying stages of development as with children, or declination as with the aged. Such relationships establish *a society* of changing composition embracing various *dynamic interplays*[17].

A breakdown in living, manifest as mental disorder, may occur as a consequence of causative factors in any of these enmeshed areas: each is a field of active research endeavour.

Genetic studies continue to be pursued in their own right. In the past they have carried the connotation of a nihilistic treatment opportunity, but more recently they have been given a broader base and workers are viewing their subject from many different angles. For example in the field of mental deficiency the difficult problems are being approached from the biochemical, cytological, and serological positions[8]. The effect of these investigations is to open up very long term hopes of controlling the causes of mental deficiency. Already the importance of early environmental influences, particularly within the womb, is becoming more appreciated: it is against these events that the activity of a malign gene or gene complex must be viewed. Of particular importance is the relationship of specific genes to biochemical process. Phenyl pyruvic oligophrenia is an example in the realm of mental deficiency: the suggestion that the schizophrenic gene reveals itself through an alteration of the enzyme system governing uric acid metabolism has arisen as an interesting possibility.

Biochemical investigations presume a metabolic basis for some forms of mental disorder. Regardless of any such presumption a tremendous amount of work is proceeding in the field of neurochemistry and normal brain metabolism[14]. The application of this work to the psychiatric clinical field is not yet ripe and a relationship between the normal findings and those provisionally uncovered in the field is still uncertain. In the field there is a continuing effort, particularly with schizophrenic patients to isolate and implicate toxic amine products. The searches yield suggestive but capricious results.

In consequence of biochemical studies, the notion of the brain as a complex of tissues with differential chemical activity is emerging strongly. The differing local chemistry is an attractive explanation of the varying effects of drugs. New pharmacological agents, developed empirically, have had astounding effects, both tranquilizing and energizing, on disturbed and depressed patients in mental hospitals. In studying the effects of these agents it has been shown that similar end results are brought about by dissimilar actions[20]. The complexity of chemical relations within the brain is very apparent.

The complications of chemical interplays are compounded by the evidence of fluctuant reaction to stress initiated at the endocrine level of adaptation. The brain, of all bodily organs, is never static in function but is continuously reactive. Its reactivity is mirrored in the endocrine system with feed back effects that modify the original response. The teasing out of these interplays is a continuing work[18].

The anatomical structure and

(continued on page 74)

Community Services

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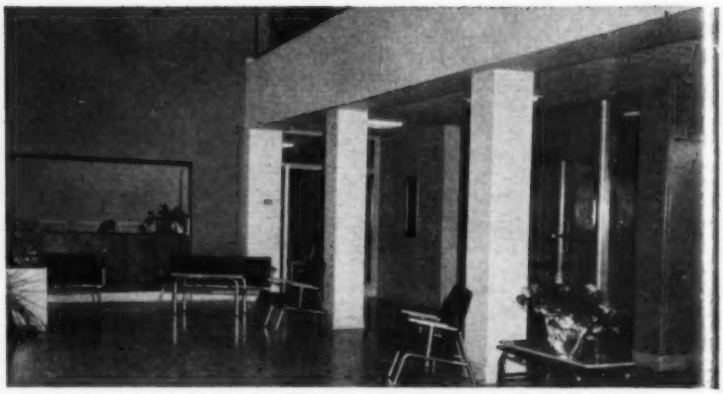

Foyer of the new Ontario Hospital, Kingston.

ONE of the most interesting and challenging aspects of present day psychiatry is the application of psychiatric insights and skills and the patterning of services in the community. At the beginning of the century, when the practice of psychiatry was confined to the mental hospitals, this subject was of little importance. In the intervening years, concepts of care have changed. A number of new and different psychiatric facilities have been introduced in the community, and the barriers between hospital and communities are gradually being trampled down.

Developments in Ontario

The need for out-patient psychiatric services was officially recognized by the Ontario Department of Health in 1926, when the out-patient department of the Toronto Psychiatric Hospital was established. In 1930, plans were made for a net-work of mental health clinics throughout the province in the hope that early and readily available psychiatric assistance would obviate the necessity of admitting many of the mentally sick to mental hospitals. Shortly thereafter, mental health clinics were established at six Ontario Hospitals. Each of these clinics maintained a regular schedule of visits to the larger population centres served by the hospital. Although the diagnostic and treatment services which they offered to adults and children were used most extensively by the family physician, educational and welfare agencies, and the courts, were quick to take advantage of this assistance. In 1946, the Department of Health appointed the first of five "Area Consultants". Utilizing accommodation provided for them in the general hospital, each of these psychiatrists shaped a mental health service for the community in which they were located.

Since 1946, a number of out-patient departments have been opened in the Ontario Hospitals and other full-time clinics have been established in the community, including two child guidance clinics, and a forensic clinic. At the present time, there are twenty full-time provincial mental health clinics in operation. In addition to these out-patient facilities, two day-care centres were established in 1958 and a third is about ready to receive patients. During the calendar year 1958 these facilities provided assistance to 13,000 residents of the province.

This expansion of provincial services during the past decade has been supplemented by an increasing number of community mental health services established by local health agencies, with assistance made available through National Health Grants.

Since 1952, federal and provincial grants have also been made available to general hospitals for the construction of psychiatric units. In this period, grants have been approved for the provision of 441 beds for the treatment of psychiatric disorders in 14 of the general hospitals throughout the province. The 11 units operating in 1958 provided short-term intensive treatment services to 3,961 patients, of which 3,275 or over 85 per cent returned to their homes on discharge.

The appearance of these facilities in the community can be attributed, in part, to the acceptance of psychiatry as a branch of medical practice, a wider recognition of the need for psychiatric services, the increased number of psychiatrists available, and the improvements in diagnostic and treatment methods. These advantages have also had their effect on the practice of psychiatry within the mental hospital. In fact, most of the methods employed in the community services have first been tried and tested in the hospitals. It is unfortunate however, that most mental hospitals have been bound by tradition, and in some instances, by legislation, to direct all of their resources to the care of patients committed to that hospital. This sharp delineation of responsibility, plus the threat of isolation and the stigma identified with admission to a mental hospital, has added impetus to the development of other facilities in the community. It should not be assumed, however, that this pattern of development, which is common on this continent, is the only way or the most desirable way of serving the community. In some countries, notably the Netherlands and Great Britain, it has been convincingly demonstrated that a mental hospital can extend its program to meet many of the needs

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in the community for in-patient and out-patient treatment services, including home care.

Focus on the Patient in the Community

Current thinking is centred around the management of the patient in the community. Although the uninformed person recognizes only quantitative differences in mental illness there are, in fact, many different kinds of mental disorder, and a wide variety of diagnostic and treatment measures are employed in the management of these illnesses. It has been demonstrated that much of the diagnosis and treatment can be carried out on an out-patient basis. A number of patients will, however, at some stage of their illness, require admission to a hospital for a short period of observation, investigation, or intensive treatment. Of this number, a few will remain in hospital for an indefinite period.

A community will therefore need to have ready access to a full range of out-patient and in-patient facilities which can provide diagnostic and treatment services in accordance with the patient's needs. While it is impractical to think in terms of a full range of facilities in each and every community, it is recognized that separation from the home and family, and loss of the many other supportive relationships enjoyed by the patient, give rise to additional problems. Insofar as it is possible, and practical, disruption in the patient's usual pattern of living should be avoided.

Since the various types of diagnostic and treatment facilities are the subject of other articles in this series, it is unnecessary to describe them in detail here. It should be stated, however, that there has been a tendency for these facilities to function independently, and one of the major problems in the patterning of services is that of co-ordinating and integrating the various resources in a community. Since these facilities may include individual, corporate, municipal and state interests, a well integrated program can only be achieved by close collaboration at all levels of public service.

The emotionally disturbed or mentally sick child, particularly in the younger age group, presents problems of diagnosis and treatment that are different from those seen in adults. Although a somewhat greater proportion of the mentally ill children, as compared to adults, can be managed on an out-patient basis, some children will require admission to a hospital. Similarly, a range of out-patient and in-patient facilities will be required for the retarded child in the community. While it is customary for many mental health clinics to provide assistance to both adults and children, there is a need for specialized in-patient and out-patient diagnostic and treatment centres for the mentally sick and the retarded child.

Supportive Services

The diagnostic and treatment services, which are required for the care of the sick, form the framework of the community mental health program. Experience in providing a direct service to patients has taught us that there are many factors relating to the patient's environment, and his relationships with other people, that contribute to his illness. These influences cannot be ignored. We have accepted the fact that the climate of the home and the early relationships in the family provide the foundation for growth and development. We are now beginning to recognize the importance of the teacher, the employer and the clergy in building mental health.

Similarly, most communities have accepted the need of services for those in trouble, and we are beginning to see these agencies, the courts, the welfare and public health departments, as "first aid posts" with a responsibility to protect the mental health of those whom they serve.

Diagnostic and treatment services can only function effectively against such a background of supportive services. These resources have not been developed, or utilized effectively. Professional workers in the mental health field, in addition to providing direct services to those who are ill, will need to give guidance and direction to all who carry a responsibility for building and protecting mental health in the community.

Need for Education

The third element of a community mental health program is education. It is my opinion that the greatest obstacle to be overcome in our efforts to control and prevent mental illness, is the attitude of the general public to such disorders. The often repeated statement that more beds are required for the treatment of mental illness than for all other sickness combined appears to be of little importance to the general public. The suffering, disability, loss of man power due to mental illness, and the cost of care for these patients, is a tremendous burden on our society. Many employers, landlords, neighbours, and even patients' families are still intolerant of mental illness and avoid any contact with those in whom they suspect such a disorder. All of the important advantages of a community oriented program will be lost if the community refuses to accept, to tolerate, and to help those who become mentally sick.

While significant gains have been made in the treatment of these disorders, medical science could provide still more effective methods of preventing and treating mental illness if sufficient funds were set aside for research. Moreover, the advances in treatment techniques, even those now at our disposal, will be of little value unless sufficient funds are provided to employ the staff required to bring these benefits to the patient. Surely an informed public will recognize these needs and support every effort made on their behalf.

A Glimpse of the Future

Changes are occurring so quickly these days that it is hard to keep pace. There is no question that industrial advances with attendant trends in urbanization and migration will continue. These forces can be expected to alter our way of life and present new problems of adjustment. Hopefully, further advances in the field of psychiatry and related disciplines will provide improved methods of preventing and treating mental disorders. Those who offer mental health services will need to keep pace with the changing needs in the community and continually revise their program and methods, taking advantage of those insights and techniques that are of proven value.

A local mental health board, or advisory committee, which is a part of many mental health programs, represents an attempt to assess local needs, interpret developments, and ensure participation and support of the program. In view of the limited number of professional workers who are available in the mental health field, it is particularly important that their resources and skills be used to best advantage. Since individuals and agencies tend to view mental health services in terms of their own needs, some means of co-ordinating services will

(concluded on page 86)

at the Peterborough Civic Hospital

Psychiatric Service

J. S. Pratten, M.D.
Peterborough, Ont.

DOES your community require a psychiatric service? It is the premise of this article that every district which includes 50,000 or more people must have some psychiatric facilities available in order to provide currently acceptable medical care for the residents of that area.[1]* Various community agencies as well as doctors, clergy, lawyers, and education authorities are beginning to insist that psychiatric services be available. Psychiatry is a branch of medicine; it has to do with the diagnosis and treatment of mental disorders. Most of these are not the serious illnesses which require admission to specialized psychiatric hospitals, but are conditions which may be treated quite successfully in the community.

In community psychiatry we are mainly concerned about the hundreds of thousands of people in our country who need help, and could be helped, with problems of emotional illnesses, if more adequate treatment services were available. It has been estimated by different studies that between ten and twenty percent of a general population has some degree of emotional illness which could be treated.[1] In this psychiatric clinic less than ten per cent of the case load require admission to a psychiatric hospital.

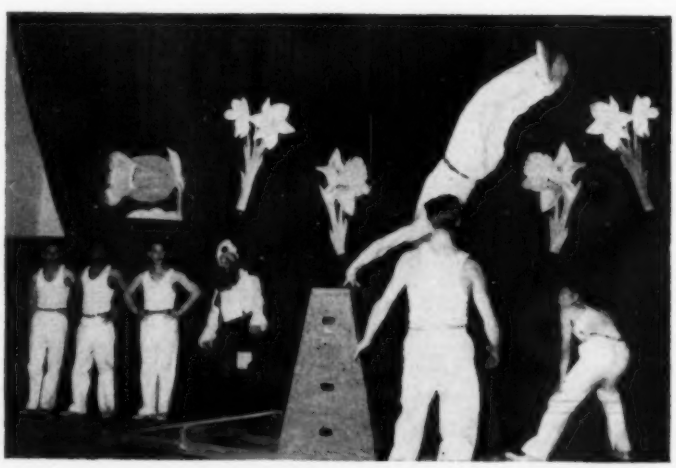
An editorial comment[2] during January 1959 had the following to say about the Ontario program: "Two significant trends are evident . . . (one is) the increasing use of clinics and general hospital beds for patients with early mental disorders who are not ill enough to require admission to a mental hospital. Patients visit clinics just as they would visit the out-patient department of a hospital for treatment of a physical disability . . . (The other trend) is the psychological effect on the public at large. When it is possible to treat both physical and mental illnesses in the same hospital the gap between the two is narrowed in the public mind . . . These (community) facilities perform an invaluable function."

The Patients

Who are the people who need treatment in the community? All of us are potentially liable to some form of emotional disorder. Such an illness does not just simply happen. Our heredity, our background of early training and experience in childhood, our physical health, and all the other experiences through which we live, have a bearing on our emotional stability and our ability to cope with the stresses and strains of living.

How many such people are there, and what types of illnesses do they have? Let us consider the example of a community clinic which draws its patients from about 100,000 people. This is like the city of Peterborough and the surrounding area of villages, towns and farms. We know that in this sample population there are about 10,000 seriously ill neurotic persons. These are people who are in touch with their environment and able to carry on "normal" lives to some extent but who have become so emotionally upset, so socially maladjusted, that they exhibit a form of mental disorder. Their multiple symptoms have resulted from the adoption of various methods of defense against their emotional conflicts. These people are trying to protect their "self", their inner personality, from certain conflicts and problems which they are unable to resolve. These cases are the majority of the work load of a psychiatric clinic.

There are, in addition, some 3,000 psychosomatic patients, physically ill people, but ill because they have certain diseases that are often found to be compounded of physical pathology and psychopathology as contributing causes to the disorder. These conditions may involve the skin, the gastro-intestinal, respiratory,



Tumbling at a Variety Show at St. Thomas

The author is director of the Community Mental Health Clinic at the Peterborough Civic Hospital, Peterborough, Ont. He is also a consultant in psychiatry at the hospital.
**For references, see page 96.*

GRIDDLE GLORY: Pancakes rate high on the menu when they're made light and thin, and wrapped around Kraft Cream Loaf whipped to airy smoothness. Serve with Kraft PC Table Syrup.

TASTY FOURSOME: Two pairs on a plate that customers "go for"—a Kraft Ketchup PC for the french fries and a Cranberry Sauce PC for the fried chicken.

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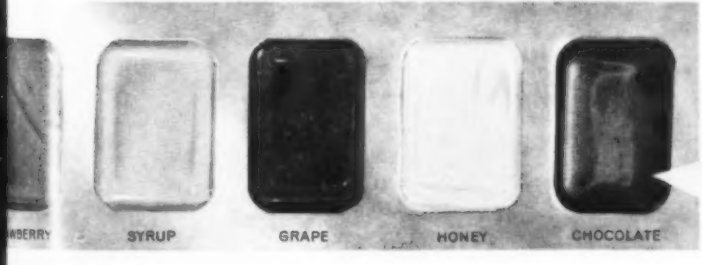

menu-planners' PC CHECK-LIST

Jams and Jellies	Apple, Mint-Flavored Apple, Grape, Currant, Strawberry, Black Raspberry, Orange Marmalade, Cranberry Sauce	For Toast, Sandwiches, Entrees
Condiments	Mustard, Ketchup	For Burgers, French Fries, Sandwiches
Dressings	French, Miracle Whip Salad Dressing, Mayonnaise, Tartar Sauce	For Salads, Fish
Toppings	Caramel, Chocolate, Strawberry	For Ice Cream Sundaes, Desserts
Syrups	Maple-Flavored Syrup; Honey	For Waffles, Pancakes, Chicken
20 PCs per tray	10 Trays to a carton (Syrup is 5 trays per ctn.)	With PCs you control costs, portions and quality

or other systems of the body. Some forms of arthritis, heart disease and obesity are psychosomatic illnesses. Of course, these patients are frequently in general hospitals, and in order that these patients be treated properly, after full investigation, they require the services of psychiatric consultants.

We know that a minimum of one per cent of any unselected population are mentally defective. These cases can be investigated and a great deal of help can be given to parents, to school authorities, and to other community agencies in assisting the development of persons with limited intelligence, in order that they may reach their optimum level of education and vocational training.

There will be some 600 of these 100,000 people who are psychotic. That means they have a serious mental illness, and usually require admission to mental hospitals for more intensive and longer term treatment than might be offered in most general hospitals.

There are at least 1,500 alcoholics in this group. With present methods of drug therapy and psychotherapy more help can be given to these sick people than in former years. Attempts can be made to keep them at their jobs and offer them psychiatric treatment while they continue at home.

There are about 10,000 of the total population sample over sixty years of age, and these people constitute an increasing problem in each community. We need suitable homes and places where they can live and be cared for in our communities. It is generally agreed that they should not be sent to mental hospitals miles away from their friends and families.

There are other disturbed people in our population who are seeking help and relief from their suffering. Some of the people with marital problems, some of those in difficulty with the law, and others who frequently lose their jobs, may be emotionally ill, and could be helped to achieve better health and happiness. Studies have shown that at least thirty per cent of patients who attend doctors' offices are found to suffer from disturbed emotional states or personality disorders which lead to their various symptoms.

This clinic offers a general psychiatric service. We see all ages of patients, from all social and economic levels, suffering from all types of psychiatric disorders. We function as a medical agency and accept referrals from doctors or recognized social agencies, such as the court or Children's Aid Society.

The Staff

The best psychiatric treatment requires the co-operation of many different skills, in many different persons, to deal with the complicated physical, mental, social, environmental, and other factors which result in the breakdown in living shown by an individual patient. To function properly in the evaluation, diagnosis, and treatment of emotional disorders, a competent psychiatrist will utilize the special training of psychologists, social workers, public health nurses, the personnel of other agencies and people in the community outside the clinic.

We employ a public health nurse in the clinic who has assumed some of the social work rôles, and has strengthened and expanded the relationships among hospital, clinic, and health department. A competent nurse can do much toward developing the co-ordinated and co-operative efforts necessary to improve mental hygiene practices. This may be a major focus for public health in the future.

In our frame of reference, the secretary for a clinic team is as important as the professional staff. She is the contact between the clinic and the doctors, the patients, and the community at large. The attitudes and feelings which she expresses via the telephone and the personal contacts made as she receives patients and takes the statistical information from them, are of prime importance in the acceptance of services.

For most patients, the first contact with professional staff comes with the series of intake interviews, usually conducted by a social worker. During these several hours a detailed exploration of the client is undertaken. The intake process includes a psychiatric history. The reasons for referral are explored, and the patient's feelings about attending the clinic are discussed. It is vital to establish how the patient might be helped and in what manner he is motivated toward assistance. The social worker is concerned with the social and environmental factors which are involved in the patient's illness, and is in contact with workers from other agencies, employers, and relatives in order to establish a diagnosis and plan a program of treatment.

Much of the social worker's time in this clinic is spent with the parents of children referred to the child guidance department. The parents are seen for the intake process and the whole family constellation is studied in order to determine what has caused the problems leading to referral, and to help determine appropriate solutions for the family's difficulties.

In this setting the social workers have been invaluable in carrying on a research project as a part of the clinic's activities. This has involved a study of our case load by means of follow-up procedures during which we contact each patient and/or members of the family and the doctor con-

Typical classroom at Thistletown Hospital

cerned one year after termination of the case. At this time the subsequent adjustment of the patient is reviewed and an attempt is made to evaluate whether our recommendations were reasonable, whether they were carried out, and what effect this had with regard to the patient's illness and subsequent history.

The psychologist in a community clinic should have Ph.D. training with clinical experience. He is responsible for aiding the physician in the diagnosis and therapy of patients. This is done by means of his training in the use of, and in the interpretation of the many psychological tests for evaluating intellectual and personality factors which have contributed to the patient's development and present difficulties. In the Peterborough clinic the psychologists do much of the work with children by testing procedures and continued therapy with selected cases. A play-therapy room with recording apparatus and one-way mirror, for observation from an adjoining office, is used to make treatment of children more effective. The psychologist also does some psychotherapy with adults whose illnesses are primarily determined by disturbed psychological processes. One third of his time is spent with children, while another third is taken up by psychological testing procedures. Consultations with workers from other agencies, such as the school health and guidance departments, and Children's Aid, are important in the work with children. We feel these contacts with other agencies are most important and are an expanding focus of clinic practice in community psychiatry.

The psychologist is specially trained in research methods so that he becomes the responsible person in assisting other members of the staff in collecting and evaluating data with regard to the clinic function. It is our belief that a psychiatric clinic has an exceptional opportunity for promoting research projects. We must be careful not to delude ourselves about the extent of our knowledge of human behaviour, thinking and feeling. We are learning more and coming to understand how to help mentally ill people by various therapies. However, there is still much to be learned, and in a general psychiatric clinic it seems that there is an exceptional opportunity to collect and study data so that we might help ourselves to do a better job, and, hopefully, provide information which will enable others to formulate their procedures in such a way that their patients may be increasingly benefited.

The staff of a psychiatric clinic can be most helpful to the patients they serve when they function as a co-ordinated team. One member may be treating an individual patient yet the facilities of the whole group are always ready for consultation, for staff conferences or for service. For example, the social worker may be working with the relatives of a patient under treatment by the psychiatrist; or a child may be in play-therapy and the mother or father may be undergoing concurrent therapy with the social worker. In other cases, two staff members may be working in group therapy with several members of one family or with a mixed group of patients in order to help them to develop greater social skills and understanding of themselves. All the staff are encouraged to participate in the increasing use of interagency conferences and contacts with others in the community who might help with the understanding and the treatment of our patients.

The Clinic

The Peterborough clinic is a provincial service which is located in a general hospital. No matter what the location or administrative arrangements may be, a clinic will need to establish satisfactory working relationships within the community; with the general hospital, civic organizations, and the members of various agencies and groups such as service clubs, in order to gain acceptance and function effectively. Community psychiatric clinics are moving in the direction of closer liaison with general hospital psychiatric units and with the mental hospitals to which patients might go for treatment. The more a continuity of care can be developed in terms of staff, patients, and the facilities in which patients are treated, the better the treatment results should be.

We now have various drugs which are used to improve the patients' symptoms, and relieve their feelings of distress. Drugs may aid the therapists' relations with patients during the process of psychotherapy. Medications are now available which relieve agitation, various manifestations of anxiety, and feelings of depression. In continued use are electroshock therapies to relieve more persistent depressions. We find that the majority receiving ECT in this clinic are now out-patients, rather than patients in hospital.

In addition to the services discussed, the staff frequently participate in indirect services which involve them in various community activities. These are a part of communication and education and range from participating in organizations such as the Canadian Mental Health Association, the local Health and Welfare Association, et cetera, to being members of panels at home and school meetings, giving addresses at service clubs and other meetings of a more public nature. The clinic staff also give lectures to nurses and conduct night school classes.

Mention should be made of the developing liaison between public health and psychiatry. A W.H.O. report[3] states: "The greatest public health problem at the present time is mental illness. It fills more hospital beds than cancer, heart disease and tuberculosis combined; and for every totally disabled inmate of a mental hospital at least two others are living in the outer world, not sick enough to be institutionalized, not well enough to live healthy, happy lives". The public health nurse functions in the community and has knowledge of families and their problems with home life, school, economics and housing, which is most valuable in the work of a psychiatric service.

The development of group therapy has been mentioned and it is my opinion that psychiatric services will train more staff to do more group and activity therapies during the coming years. These methods of treatment have several advantages with selected cases over individual therapy and in many instances two or three types of treatment may be indicated in the management of a specific patient. There are trends towards emergency psychiatric care and in several American cities experimental projects are being developed.[4] In Amsterdam, Holland, a plan of 24-hour psychiatric care operates under the guidance of the municipal health department.[5]

There are limits to our time, and to our case load. If more cases are seen for shorter periods of time,

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Psychiatric Unit in the General Hospital

F. C. R. Chalke, M.D.,
Ottawa, Ont.

ONE of the most dramatic changes in the pattern of facilities for the care of mental illness has been the development of psychiatric units in general hospitals. Though there have been historically noteworthy psychiatric wards in a few general hospitals (such as the Philadelphia General Hospital) for two hundred years, the number of units has increased markedly since the second world war in both Canada and the United States. The reasons for the growth are many but certainly include the recognition of the treatability of psychiatric illnesses, the increase in psychiatrists in extra-mural practice and the discovery of new methods of therapy. Canadian hospitals have shared and even pioneered in some aspects of this change.

More than half of all general hospitals with a capacity of over 100 beds in Canada state that they have some type of psychiatric service.[1]* For the majority, the service consists of a consultant psychiatrist on the attending staff of the hospital, limited admission for diagnosis, observation or detention to the medical wards of the hospital. However, there are now 32 Canadian general hospitals which have separate units with organized psychiatric departments or services, representing a total of 1,000 beds and caring for about 15,000 patients annually.

The term "psychiatric unit" is by custom used to designate any separate ward, wing or detached building with more than ten beds, operating under the governing body of a general hospital, and set aside primarily for the care of patients with psychiatric disorders. At first, these units were accommodated in converted space but more and more units are being designed and built specifically for their purpose. Experience is elucidating the unique requirements from which hospital architects are evolving therapeutically advantageous structures. The initial traditional "maximum security" design with barred windows, locked doors, absence of bed lamps, open toilets and bathing areas has given way to furnishings and fittings which foster more confidence in and comfort for the patient. Although a few general hospital units are still closed (locked), often for a special local reason, the majority are completely open. Another distinctive feature of psychiatric units is the need for greater total area per bed than on general medical wards—twice the space according to architects — to provide the treatment areas which include the therapists' offices (the "operating rooms" of psychiatrists) as well as occupational therapy and group therapy space. Some units are now designed so that this "therapy space" can be used by in-patients, day hospital patients and out-patients.

The Patients

At the present time, psychiatric units look after more than a third of all first admissions for psychiatric disorder to hospitals in Canada.[2] The average length of stay is approximately three to four weeks.

If one reviews the precentage distribution by diagnostic category of patients treated in the various units across Canada there is a surprising similarity. Roughly half the patients are classified as suffering from psychoneurosis, one-third from psychosis and the remainder a combination of character disorder, neurological disease and toxic deliria. Such codified statistics do not, of course,

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**For references, see page 99.*

Ontario Hospital, St. Thomas.

indicate the patients most appropriately cared for in general hospitals, since many of the currently used diagnostic names reflect a minimum of information as to the aetiology, symptoms, severity of the illness or assets of the patient. For example, chronic brain disorder (cardiovascular) might suggest a group unlikely to benefit from short term care, yet many patients are discharged (improved) to home, nursing homes, convalescent hospitals, after being admitted with confusion, anxiety or paranoid symptoms associated with this condition. Thus, because of the wide variation and unique features characterizing psychiatric illness, it is simpler to mention patients usually not cared for and leave it understood that more and more patients are found to be treatable in the general hospital.

Most general hospital units do not undertake to treat adequately evaluated patients who are unlikely to benefit from short term care. The conditions in this group include simple schizophrenics, mental retardations, and character disorders. Rarely is an open general hospital unit a suitable place for treatment of alcohol or drug addiction in the withdrawal and rehabilitation phases. Some psychiatric units serve as the "drying out" ward for acute alcoholic intoxication for the whole hospital. Other hospitals admit acute alcoholics to medical wards and refer only those with delirium tremens and other psychiatric sequelae to the psychiatric unit.

When the earlier units were founded there was a commonly held idea that they would be particularly suitable, by virtue of their program and *milieu*, as locations for treatment of peptic ulcer, rheumatoid arthritis, neurodermatitis, etc. Many were even entitled psychosomatic wards with this purpose in mind. Although the assumption that such an environment would be therapeutically beneficial may be valid, in fact an insignificant number of patients have been treated for these as primary conditions in any general hospital psychiatric unit in Canada. Most units in general hospitals avoid admitting children, except in unusual circumstances for diagnosis. When this is necessary special temporary staff arrangements, as pointed out by Ozarin[3] are required, both for the welfare of the child and adult patients. With these exceptions, then, most units can treat the range of common psychiatric disorders.

Somewhere between five to eight per cent of patients are transferred after investigation directly from general hospital units to mental hospitals for longer term treatment. Proper studies, however, of patient movement in and out of different psychiatric units and mental hospitals have not yet been carried out. Isolated surveys have shown that about another ten per cent of general hospital patients discharged home are subsequently admitted to mental hospitals. Those units which have been operating more than five years find that about one quarter of their case load are readmissions to the same unit.

The Staff

The professional staff requirements of general hospital units reveal a high staff/patient ratio which is essential since all the patients are acutely ill and the actual admission rate often exceeds that of large mental hospitals.

More than half the units in Canadian hospitals are situated in university teaching centres. The clinical staff is enriched by support from university departments of psychiatry and by the presence of resident physicians who are the post graduate students of the associated university. At the opposite extreme, there are units where the one or two psychiatrists in practice in the community are the only physicians available. In most cases psychiatrists are appointed to the staff as are other physicians of the hospital.

There is general agreement that an effectively operated unit, like an effectively operated mental hospital, requires a psychiatrist to be administratively responsible. The reason in both instances is that current theory holds that the immediate emotional atmosphere of the treatment setting is an important therapeutic instrument. This atmosphere, climate, or *milieu*, must be built with understanding, trained personnel, who, under the best possible working conditions, operate as a team with properly established lines of authority and communication. Few psychiatric units are large enough to require anyone full time as administrator. The problem is more easily solved in those units run solely by provincial departments of health or universities when an administrator can be appointed. In other units it is an unsettled question how much time is required and how it is to be obtained.

Most of the psychiatric units have developed closely affiliated out-patient services. However, few have yet capitalized on the benefits of day hospital programs and those which have are in provinces which have not yet introduced hospital insurance. Fewer than half of all the units in Canada have a full complement of professional staff including psychologist, social worker and occupational therapist.

At this time it is difficult to judge the adequacy of service being offered in the various units, since standards against which departments of psychiatry could be evaluated have not yet been promulgated. The standards for accreditation of mental hospitals by the American Psychiatric Association are of limited usefulness and neither the Canadian nor American bodies inspecting general hospitals have evolved a basis for assessing psychiatric units. At present, particularly with the advent of hospital insurance plans, there is interest in appraising the value of such units.

"Advantages and Disadvantages"

Because psychiatric units are of such recent origin, because they have been introduced in the larger context of a flux in medical care and because of the particularly revolutionary changes in psychiatric care, no final balance sheet can be drawn. The pros and cons of the development are listed differently by each authority, coloured partly by local situations and partly by partisan viewpoints.

It is generally agreed that these units have demonstrated that it is possible to treat effectively a major proportion of psychiatric illness in general hospitals on the basis of voluntary admission. There are few opponents of the idea that these units have fostered a greater acceptance and understanding of psychiatric conditions by the medical profession in general. This has been achieved by mere propinquity; by the collaborative care of patients by family practitioners and other specialists when concurrent physical disease was present; and by

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Care of the Mentally Retarded

H. F. Frank, M.D.,
Smiths Falls, Ont.

THE mentally retarded present us with a most serious medical and social problem. There is a new outlook and a tremendous upsurge of interest generally. The whole problem is in a state of flux and, in truth, confusion. There is not yet really a satisfactory definition, nor a common language of nomenclature; nor is there a clear-cut formation of the path we should follow. It is a rather arid area in which new approaches are developed with difficulty.

Mental retardation can be defined as arrested or impaired intellectual development so that at the time a mentally handicapped child reaches maturity he has not yet acquired the usual adult intellectual capacity. Most authorities substantially agree that mental retardation contains three concepts: (a) limitation of intelligence, due to (b) lack of normal mental development, rather than to mental disease or deterioration, which shows itself in (c) social, educational and economic incompetence.

It is not enough to know that a child is mentally handicapped. He may be mentally like an average infant or like an average child approaching maturity. The approach to the child and expectations from training depend upon an understanding of the degree of the handicap and the presence of other disabilities, either physical or emotional.

The mentally handicapped are generally divided into the educable, the trainable, and the custodial. The educable mentally handicapped are those who can profit from a degree of practical educational training. The trainable are unable to profit from educational training but are capable of absorbing training in the direction of simple tasks and activities. The custodial group consists of those who are so severely intellectually and physically handicapped that they are unable to profit from any type of training and these must spend the remainder of their days receiving adequate nursing care in a suitable environment.

Mental retardation is actually not a disease *per se;* rather it is a symptom of systemic disorder, physical, emotional or social. Those who are handicapped will present symptoms of varying types and degrees other than mental disability; symptoms which are related to the same basic cause and which in turn may detrimentally influence the potential optimum functioning of the intellectual capacity. The intellectual disability as it is related to an organic cause must be regarded as a permanent disability. Planning for the mentally retarded child is concerned generally with helping him to develop to the fullest extent whatever intellectual capacity remains to him.

It is not possible to identify mentally retarded children merely by observation; appearances are often deceiving. They do not always have a dull expression and some are alert and vivacious. The mildly mentally handicapped especially, often escape notice because their appearance is normal. Sometimes, too, unpleasant personal habits or mannerisms lead to a hasty judgment of mental defect. Certainly, physical disabilities, particularly sensory ones, also occasionally lead to a faulty decision. There is a real need for adequate diagnostic clinics—a more intensive training of mental health clinic personnel with reference to the whole problem of mental retardation and a more widespread use of such clinics — and also greater use of the hospital school facilities for diagnostic and counselling purposes.

Within recent years a good deal of knowledge has been gained concerning causation of some types of mental defect, such as cretinism, phenylketonuria, galactosemia, et cetera. Diagnostic and preventive measures are now readily available for some of these types; and the physician must be constantly alert along these lines. Further research lies in the direction of learning more of the basic development of the nervous system and the biochemistry of the human organism.

Until very recent years the only recourse for parents of retarded children was institutionalization. But the community has tended more and more to provide facilities for the care and training of this handicapped group.

The institution should be regarded as only one of the facilities in the total and longitudinal approach to the retarded individual. The community generally has become increasingly conscious of its responsibilities to the retarded child and its parents. For many years local boards of education have provided auxiliary classes and in some instances, junior vocational classes, for the educable retarded group. During the past few years the Ontario Association for Retarded Children has, through the local associations, been arranging

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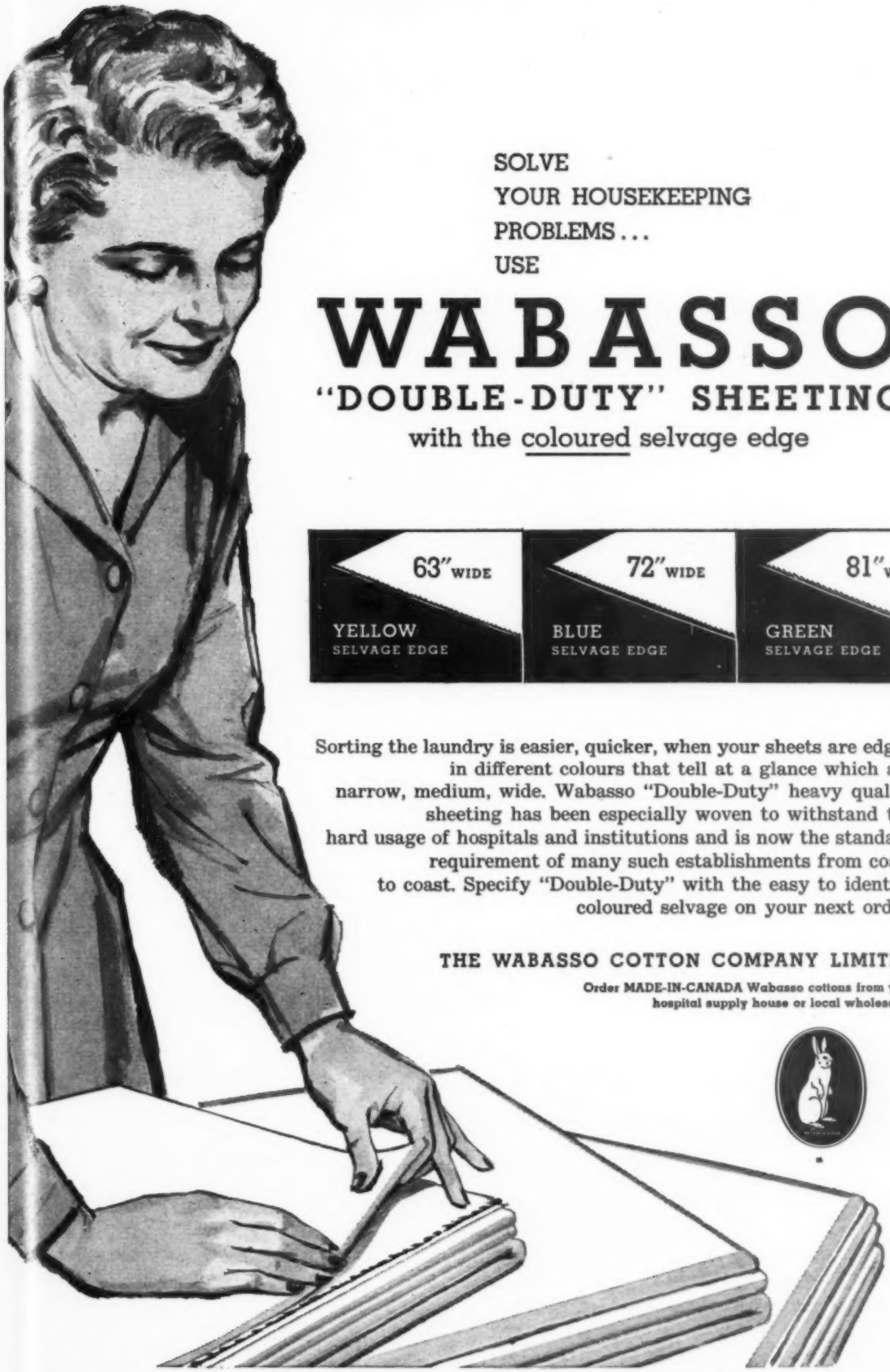
Dr. Frank is superintendent of the Ontario Hospital School at Smiths Falls, Ont.



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Retarded
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for the provision of special classes for the young trainable retardate. At present, there are such classes in well over 50 communities throughout the province. A sheltered workshop has been established by the Metropolitan Toronto association and during the past year this has proven to be a very satisfactory facility for the young adult retardate. Two or three of the larger communities are now in the process of developing similar facilities. Most local associations also provide counselling arrangements for parents who wish to keep a retarded child at home.

The Ontario Hospital school (there are now two) is a comprehensive institution to which are admitted all types of mentally retarded children under the age of sixteen years. The institution is geared to meet the individual needs of each child. It provides facilities for complete medical and psychiatric care and treatment. This includes a consultant staff to meet all the varied medical and surgical needs of the retarded. In the Institution the custodial group receives adequate care to provide for a healthy and happy life; the trainable group receives training in the necessary habits of self care and socialization; and every effort is made to provide such children with simple unskilled occupational activities which can be satisfactorily undertaken in a supervised environment. The educable group receives an educational training in keeping with each child's capacity and vocational training, so that the young adult retardate is provided with semi-skilled and unskilled occupational activities. Very many of this last group are capable of being rehabilitated in the community on a self sufficient basis.

Many retarded children can be cared for at home. The needs of all children are basically the same; it is only that the retarded child must have these needs met in special ways. The first years of life are tremendously important for any child. During these early years the child gains the means of living with people and learns to cope with everyday life situations. The attitudes and emotional climate have an influence on how well any child uses the abilities it has; and these, too, are developed in the early years. The retarded child also requires these elements of successful living. Children need the affection and attention that can be best provided by a loving family within a home environment. It is becoming increasingly possible for a retarded child to stay in his own home and to grow up in the community successfully. The tendency to institutionalize certain types of mentally retarded children during infancy is an unfortunate one; and it may be detrimental to the adequate development of the child intellectually and emotionally. This is especially true of such types as the Mongoloid retardate. The World Health Organization on the "subnormal child" emphasizes the advisability of the retarded child remaining within the home environment as long as possible. There are, of course, very young children with severe multiple handicaps and malformations whose care is proving a burden on the family and whose removal to a hospital setting would be beneficial both to the child and the family.

The needs required to deal with the total problem presented by the mentally retarded can only be touched on very briefly in this short article. It is generally accepted that about 3 per cent of the population present some degree of retardation and that about 5 to 10 per cent of this number will require institutionalization. At present the two hospital schools — at Orillia and Smiths Falls— are overcrowded to a distressing degree and many hundreds of children are on the waiting list. A third hospital school at Cedar Springs will be opened in 1961 and obviously

(continued on page 104)

Coming Conventions

Feb. 24-26—Quebec Hospital Association, annual convention, Queen Elizabeth Hotel, Montreal, Que.

Feb. 29 - Mar. 3—American College of Surgeons, Sectional Meeting for Surgeons and Nurses, The Statler Hilton, Boston, Mass.

Feb. 29 - Mar. 4—Laundry Institute, Vancouver, B.C.*

March 7 - 11 — Laundry Institute, Edmonton, Alta.*

March 14 - 18 —Laundry Institute, Saskatoon, Sask.*

March 21 - 25 — Laundry Institute, Winnipeg, Man.*

April 25-30—Third International Congress on Medical Records, Edinburgh, Scotland.

May 23 - 25 — Canadian Hospital Association Assembly Meeting, Park Plaza Hotel, Toronto, Ontario.

May 30 - June 2—Catholic Hospital Association of the United States, annual convention, Milwaukee, Wis.

June 12-16—The Canadian Society of Laboratory Technologists, 24th national convention and annual meeting, Sheraton-Mt. Royal Hotel, Montreal, Que.

June 13-17—Canadian Medical Association, Annual Meeting, Banff, Alta.

June 19-24—Canadian Nurses' Association, biennial meeting, Nova Scotian Hotel, Halifax, N.S.

June 22-25—Canadian Physiotherapy Association, annual convention, Vancouver, B.C.

June 27-29—Comité des Hôpitaux du Québec, annual convention, Provincial Exhibition Grounds, Quebec City, Que.

Aug. 28 - Sept. 2—International Society for the Welfare of Cripples, Eighth World Congress, Waldorf-Astoria, New York.

Aug. 29 - Sept. 1—American Hospital Association convention, San Francisco, California.

Sept. 6-9—Western Canada Institute for Hospital Administrators and Trustees, Queen Elizabeth Auditorium, Vancouver, B.C.

Sept. 20-21—Catholic Hospital Conference of Alberta, 17th annual meeting, Jubilee Auditorium, Edmonton, Alta.

Oct. 12-14—Saskatchewan Hospital Association, annual meeting and convention, The Bessborough Hotel, Saskatoon, Sask.

Oct. 18-20—Manitoba Hospital and Nursing Conference, Winnipeg.

Oct. 24-26—Ontario Hospital Association, annual convention, Royal York Hotel, Toronto, Ont.

***Institutes on laundry administration have been planned by the Canadian Hospital Association in co-operation with western provinces.**

The Trend is toward Integration In Hospital Planning

R. J. C. McQueen
Toronto, Ont.

Part 2

Planning Trends

For a change of pace, let us look at a few of the more specific trends in hospital planning today. Double corridor planning has become an increasingly popular design for small hospitals as well as for large ones. This means there is a service core in the centre of a ward or a department, with a corridor on either side of it, and the patients' rooms on the outside walls. This requires a wider dimension to the wing of the hospital than has been customary, but permits it to be shorter and, therefore more compact, easier to staff and service. Several of the smaller hospitals across the country have provided very efficient designs of this type and the increasing popularity of this layout ensures it a place in the future of hospital planning.

There is a definite tendency to fill in the lower floors of a hospital, particularly between the wings, to provide a service core for the entire building. This tendency applies especially to a concentration on the ground floor of emergency, radiology, laboratories, the out-patient department, the central supply and dietary services—in other words the departments which are in constant demand by both the public and the hospital. There has been a growing tendency to build the surgical suite also on a lower floor, leaving only the delivery suite on a higher level with the nursing units. In smaller hospitals, the trend is still to connect operating rooms and delivery rooms with a service corridor but to create more separation in traffic flow to offset the possibility of cross infection.

There is a trend toward the building of suburban hospitals, sometimes called shopping centre hospitals, particularly to provide obstetrical and paediatric service to the heavily populated fringes of the larger cities. These hospitals usually offer emergency service, but few of the more highly specialized medical and surgical services. The large city hospitals are thereby tending to lose their obstetrical patients and many of their children's services are being underused. The large city hospital is, in effect, becoming a specialist centre and the ordinary community services are being provided within the communities themselves and in the residential areas.

In western Canada there appears to be less demand for the two-bed, semi-private room than in the past. This is probably because a rather small percentage of the population maintains insurance coverage beyond the ward service provided by the government hospital insurance plan. In Ontario on the other hand, which has had a long experience with heavily subscribed Blue Cross semi-private enrollment, 37 per cent of the population continue to hold this excess coverage. A large number have similar plans with insurance companies. As a result, the demand for the two-bed room continues as before. Generally speaking, there is a greater demand for private rooms in general hospitals and we feel this trend will continue as people insist upon more privacy, just as they would obtain in their own home or in a hotel.

There is a much greater willingness on the part of hospital boards and communities to discard their old hospital buildings and either completely modernize them or tear them down and rebuild on the same or a separate location. This is natural. Many of our hospitals have been in existence for 50 to 70 years and have fairly well served their purpose; many others were built only as temporary structures and have come to the point where they must be rebuilt. This is part of a general attitude, however, which we note among hospital boards—to provide the best of care within the best of physical plants. Each year we are coming closer to this objective.

There is a trend toward the use of more automatic devices within hospitals, particularly for transportation of goods by conveyor. The dumb-waiter has come into disrepute in many places, especially in the central supply department, because of the danger of contaminating the shelves and the shaft. More thought is being given, however, to labour saving transportation devices and it is inevitable that we will see more of them develop with the years. New equipment does a better job and more of it is of an attractive design and finish.

There is a definite trend toward providing more toilets, close to or within the patients' rooms, even if it means reducing the over all size of the room itself. There is a slight trend also to providing more baths and/or showers for patients' rooms.

Attractive colour is being used more often in hospitals, creating a less institutional appearance. There are more courts and plants and spots of greenery appearing within the hospitals, more statuary, more murals, more paintings, more attractive draperies and softer, handsomer furniture. These are all most welcome trends which we hope will never reverse.

Less housing is being provided for personnel each year. The graduate nurse seems less and less interested in living on hospital property, even if the residence is located several blocks away. Of course, accommodation for nursing students is still provided and a few rooms are usually available for nursing and other staff in transit until they can find their own accommodation. The only type of housing which is retaining a popularity is an apartment type of residence where the staff may rent a self-contained unit at a reasonable price. Unless more of this type of accommodation is offered, it is fairly safe to predict that housing for other than nursing students will soon be a thing of the past.

There is a constant move toward more completely centralized services within the hospital and this applies to all departments. One in particular is the dietary department. I am willing to go out on a limb and predict that hospitals which do not provide centralized food service will soon find themselves completely out of date. More and more systems are being devised and are available on the market which can deliver the hot food hot and the cold food cold, permitting the entire supervision of food service to remain where it should—in the hands of the dietitian and her staff. The nursing staff consult

with them and advise about particular needs, portions and diets.

There is a definite trend toward providing more land for the hospital site. Hospital boards are learning by bitter experience that as their building must expand and as parking problems mount, there is an urgent need for more and more space. Because of this and through the experience and advice of others, it is becoming more common to provide at least seven to ten acres for a new hospital site, thereby preparing for future service to the community without inhibiting plans or their efficiency in layout and design.

More space is being provided in hospitals for teaching and for research, especially in the large hospitals. It is also noticeable that teaching space is more decentralized than in the past, with separate teaching rooms on each nursing unit when possible, and often throughout many of the service areas. This is a healthy trend, in line with modern educational techniques of bringing the classroom into the working situation.

There is a trend toward providing smaller nurseries, although much of this has been related to government requirements. In nursery layout, there has been a definite move toward placing the doctors' examination booth directly off the corridor.

Hospitals are demanding their own laundry services. Even in centres where this was formerly not considered advisable, the staff seem to feel that the availability of their own linen supply, with the responsibility for providing it, is worth more than the inconvenience of having to operate the laundry.

There is a move away from providing flower rooms in hospitals. They no longer seem so necessary when many of the florists send prepackaged and arranged flowers.

There is a trend toward providing less storage space, particularly in large hospitals where deliveries are more frequent. In smaller hospitals, however, there is still a very great need for more storage space and this is one of the greatest complaints in hospitals which have been operating for a number of years.

There is a demand for more space in the central supply department, particularly noticeable in small hospitals where the old standard of seven square feet per bed is not enough space when the packaging and autoclaving work of the operating and delivery rooms are centralized within the new department.

There is a definite trend toward single labour rooms and a greater ratio of labour beds to obstetrical beds than formerly. It used to be considered that one labour bed to ten obstetrical beds was satisfactory, but now one to eight seems to be a more definite standard. There is also a move toward providing more first stage labour rooms, with more freedom of activity for the expectant mother and usually a place for the husband to be with her until a later stage of her labour.

There is a return again to the use of the solarium for up-patients. We have gone through several stages in this facility in the past few years. Formerly, a lounge or up-patient area was provided for patients because they were in hospital for such long periods of time. Those who were convalescing used to help with some of the work around the units. These gradually came into disrepute for some reason and most of the hospitals built ten to 20 years ago made very little provision for such space. In the current days of early ambulation, however, there is a real need for up-patient space on each nursing unit. The provision of government grants for solaria space has been a mixed blessing, since practically all hospitals in recent years have provided solaria with the condition, as the government requires, that the area can be made available for patients when needed. This has meant that nearly all these rooms have been used for patients on almost a continuous basis because of the high level of occupancy in most general hospitals in this country. We are, in effect, no longer provided with up-patient space. I am not suggesting a solution but merely pointing out a trend.

There have been some unfortunate features in hospital planning in the past few years. Three of the most common are the tendencies to over-light, to under-ventilate, and to provide too few elevators. Nearly every part of the hospital (with the unfortunate exception, in certain instances, of the patient's room) is flooded with light practically all day. There seems to be a fear among electrical engineers and administrators that the place is going to be shrouded in a pall of gloom and consequently the rooms are given at least twice as much light as is required. It is a wonder that most staff and patients do not suffer from chronic headaches. There is a constant shortage of good ventilation in many areas of the hospital. Heating and ventilating engineers do not seem to be fully aware of the need for air changes in hospitals, particularly with the increased use of inside space for service departments. It is hoped that this situation will be remedied and that administrators and hospital boards will insist that this is so. Too few elevators in most vertical buildings is a problem which, I am sure, is well known to most people who work in such

(continued on page 108)

The Extension Course in Hospital Organization and Management

All those interested in enrolling in the 1960 class of the extension course in hospital organization and management should submit applications not later than March 31st. The course commences the middle of August. Because the demand for enrollment continues to be heavy, assurance can not be given that applications arriving late will be considered.

The two year program is now in its ninth year, and the certificate of graduation given by the Canadian Hospital Association has been granted to 364 persons. Those enrolled in the course spend eight months each year studying lessons at home and preparing assignments. This period is followed by an examination and a four-week intramural summer session at a specified Canadian university.

Information and application forms may be obtained by writing to: The Secretary, Committee on Education, Canadian Hospital Association, 25 Imperial Street, Toronto 7, Ontario.

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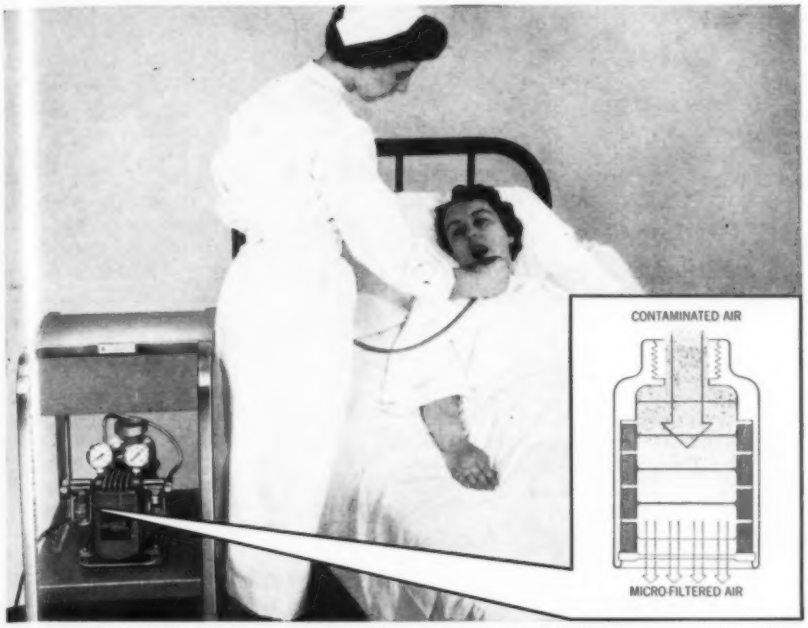

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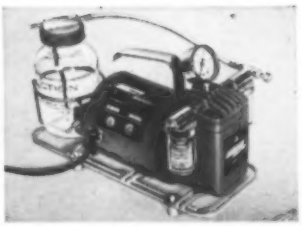

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1. Ranger, I. and O'Grady, F.: Lancet 2:299, 1958.

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Provincial Notes

Newfoundland

Plans have been approved for the new six-storey wing to be added to St. Clare's Mercy Hospital, St. John's. Construction is expected to begin early this year. The architects are Dunford, Bolton, Chadwick and Ellwood of Montreal, Que.

A fully equipped, 20-bed prefabricated hospital, used recently in northern Quebec, will be set up in Stephenville Crossing as an addition to the existing cottage hospital. The sections are approximately four by eight feet by six inches thick, and can be erected in a relatively short time. This hospital will be used primarily to provide urgently needed maternity wards, nurseries, delivery rooms, children's wards and "related facilities".

Nova Scotia

The contract for construction of the new 331-bed addition at the Halifax Infirmary, Halifax, has been awarded to the firm of J. L. Guay Limited, Montreal. The new wing will bring the hospital's total capacity to 481 beds as part of the project will include reducing the present hospital's capacity from 223 to the 150 for which it was originally designed. It will also include, in addition to the new bed capacity, an operating suite, an out-patient department with its own kitchen, and various necessary administrative facilities. Architects for the project are Franco Consiglio of Montreal and his Halifax associate, Ross McNeil.

Tenders have been called for alterations and additions to the Camp Hill Hospital, Halifax.

The contract for the building of the new Yarmouth Hospital, Yarmouth, has been awarded to the Kenney Construction Company Limited, Yarmouth. The 165-bed, four storey building will be reinforced concrete and brick. It will be fireproofed. Completion date is August, 1961.

Prince Edward Island

Safe evacuation of 11 adult patients and one baby followed the discovery of a fire at the Souris General Hospital, Souris, early in December. There were no casualties. The fire which caused an estimated loss of $20,000 was confined to the laundry room and the lower corridor of the two-storey wooden structure.

New Brunswick

The 160-bed addition to the Moncton Hospital, Moncton, will consist of six storeys of reinforced concrete and brick construction. Tenders will be called soon. The architects are Govan, Ferguson, Lindsay, Kaminker. Langley and Keenleyside, Toronto, Ont.

Quebec

The architect for the new $1,500,000, 75-bed Hôpital St. Joseph in Sept-Iles is Maurice Bouchard, Quebec City.

Arthur Lacoursière, Shawinigan Falls, will prepare plans for an extension to Hôpital Cloutier, Cap de la Madeleine. The cost is estimated at $500,000.

Ontario

The new, ranch style Milton District Hospital, Milton, has been officially opened. A one storey structure, it was designed in the form of a cross. The 54-bed, $543,000 general hospital has the latest in equipment in all departments. The architect was Clare G. MacLean, Toronto.

The opening of the Milton District Hospital marks the close of the 16 year old Milton Private Hospital. Owned and operated by Dr. C. Keith Stevenson, the institution had five rooms, 10 beds and four bassinets when it was opened in 1943. When it closed in December the hospital had grown to 17 beds and six bassinets.

The MacDonell Memorial Hospital, Cornwall, has been officially opened. This hospital for the chronically ill is operated by the Sisters of the Religious Hospitalers of St. Joseph in the former Hotel Dieu Hospital building. A $600,000 program of renovation and construction has been carried out and the building is now completely fire-resistant and has the latest in equipment. It boasts 118 beds consisting of 14 private rooms, 14 semi-private rooms and 90 public ward beds.

Manitoba

Construction has started on the new $3,000,000 service wing for the Winnipeg General Hospital, Winnipeg. The seven-storey wing replaces the old A and B wing built in 1884 and includes an extension of the present centre wing up to the seventh floor. This will provide a laboratory for clinical investigation, the bio-chemistry department, a central supply section and a 24-bed recovery room. A service room will be provided, as well as a new central kitchen in the basement, a stores department on the ground floor and a cafeteria that will seat 650 persons. A chapel and medical staff lounge will complete the facilities of the new wing. The contractor is Commonwealth Construction Co. Ltd., and the architects are Moody, Moore and Partners, Winnipeg. The completion date has been set for July, 1961.

Plans for a $2,500,000, 500-bed hospital in North Winnipeg will be held up until the survey team in Manitoba has completed its study. The hospital was to be operated by a Roman Catholic order, the Servants of Our Lady.

Saskatchewan

The new Whitewood-Moosomin Union Hospital, Whitewood, was officially opened early in December, 1959, by the Hon. Walter Erb, Health Minister for Saskatchewan.

Progress has been made on the new 10 bed, L shaped staff residence being constructed for the Davidson Union Hospital, Davidson. The $38,000 contract was awarded to Con's Construction, Davidson, in the fall of 1959.

Alberta

The board of directors of the Alberta Crippled Children's Hospital, Calgary, has decided to change the hospital's name. It will be known as the Alberta Children's Hospital. Once purely an orthopaedic institution, the hospital has recently extended its services to include general paediatrics.

Provincial approval has been granted for the construction of an $850,000 hospital for the chronically ill in Red Deer. The hospital will have 100 beds.

A combination chapel and family room has been opened at the Calgary General Hospital, Calgary. The

(continued on page 104)

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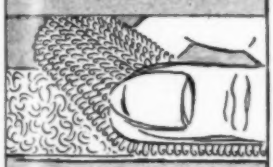

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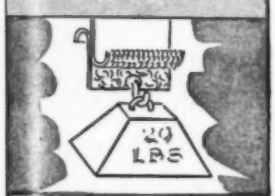
The two Velcro surfaces separate easily when "peeled" from the edge.



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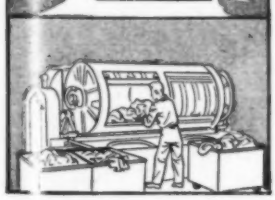

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Individual Therapy Treatment
(continued from page 44)

essentially a destructive one. It has been used much less in recent years partly due to replacement by the tranquillizing drugs. It is still considered by many to have a definite place in certain cases where other methods including intensive psychotherapy, shock therapy and tranquillizing drugs have failed and the patient is suffering from intense anxiety. Some patients have done very well and not infrequently the effects have been dramatic. The literature on the indications for this form of therapy, with reports on the results, is vast and some of it contradictory. Falconer and Schurr[6] give the following opinion on the basis of their own work and reviewing the reports of many centres: "The indication for operation should be not the diagnostic label, but the tension and anxieties which the illness has produced. The best results are obtained in the obsessive-compulsive neuroses, severe involutional, agitated and reactive depressions and in chronic anxiety states." The careful selection of cases by experienced psychiatrists and an expert rehabilitation program are of vital importance.

Drugs

Drugs have been used in the field of psychiatry from earliest times. They were prescribed for the most part to allay anxiety and excitement or induce sleep, functioning pharmacologically by a generalized sedation of the central nervous system. In the past six to seven years there has been a tremendous development in psychopharmacology beginning with a group of drugs that have come to be known as tranquillizers. One of the advantages of these newer drugs is that their action is mainly in the midbrain and in the reticular substance, with minimal effects at the cortical level. Consequently the sensorium is relatively clear. With the aid of these drugs the therapist is now able to treat in the community or in a general hospital setting certain chronic psychotic states that formerly would have required admission to a mental hospital. While the basic underlying personality is not altered, the patient may become much less reactive to hallucinations or delusions and in some cases there would appear to be a lessening or even cessation of the disordered perceptions and thinking. With psychotherapy, largely of a supportive nature, many such patients now can function indefinitely in their family and vocational settings. It is also possible now to help some patients through an acute psychotic episode without the dislocation resulting from separation from the strengths and support of their daily living. These drugs have been of much less value in the treatment of psychoneurotic illnesses and on occasion would seem to be detrimental, fostering the development of depressed states. One of the older well-tried chemicals, perhaps a barbiturate, may be quite effective. Often medication is unnecessary in the treatment of psychoneuroses if the therapist is skilled and is able and willing to devote the time to employing the most useful therapeutic instrument at his disposal, himself.

It is stated by psychiatrists practising in mental hospitals that the tranquillizing drugs have revolutionized the treatment of disturbed, noisy, destructive and hostile patients. It is now possible in a relatively short period to restore many such patients to a relaxed, orderly state in order that individual and group methods may be employed in aiming at returning the patient to his community. Many patients who formerly seemed destined to permanent hospitalization are being discharged to their family doctors or to follow-up or other clinics for continuing psychotherapy, socializing methods and medication. While some have relapsed, a goodly proportion have continued for some years adapting in the community surprisingly well. These results have had a definite positive effect not only on the patients and personnel of the hospitals concerned but on the attitude of the general public and the medical profession toward mental illness.

A very encouraging development in the past three years has been the advent of drugs that appear to have a beneficial effect on depressive illnesses. Reports to date of controlled studies and the experiences of clinicians with individual cases indicate favourable results in a high percentage of depressed patients. Already there are predictions that chemotherapy will reduce the need for electroconvulsive therapy as a somatic agent in the treatment of depressions.

The quest for yet newer and more effective drugs goes on at a feverish pace. Also proceeding at an accelerating tempo are biochemical and physiological researches into central nervous system functioning, conducted largely in university centres and research institutes. Hypotheses are being developed, attempting to explain the effects of these newer drugs in terms of enzyme chemistry, intimetabolite mechanisms and neurohumoral imbalances. Some of the more organically oriented psychiatrists see these newer drugs as the forerunners of the day when chemotherapy will be the core of treatment, specifically correcting a basic pathophysiology which is postulated as the basis of such disorders as the schizophrenias and depressed states. Whatever fundamental changes in psychiatric treatment may result eventually from future researches in biochemistry and pharmacology, in our present state of knowledge it is the generally accepted view that the newer drugs are therapeutic aids only, although very potent aids, relieving severe symptoms and facilitating the personal psychological approach to the understanding and treatment of the patient.

Renaissance

It is the opinion of some that we are witnessing a renaissance in psychiatry, with an intensive stirring and increasing research in the social and physical sciences as they relate to the study of emotional disorder. Integration and elasticity of approach are becoming bywords in modern concepts of treatment. There is no question that we have much to learn, that research and open minds are desperately needed. Even so, therapy is an increasingly satisfying experience for the doctor whose responsibility it is to treat the emotionally distressed patient.

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time as a cosmetic saleswoman which is quite satisfying to her. She is visited regularly, as she still needs reassurance and encouragement.

I.M., a salesman of 43, had D.T.'s on his third admission. Despite this, he would not admit that he was alcoholic and refused to attend the weekly Alcoholics Anonymous meetings in hospital. However, the public health nurse convinced his family that A.A. had something to offer him, and family pressure led him to join A.A. Six months' later, he is working steadily, is an enthusiastic member of A.A., and his family is happier than they have been for some years. His wife still keeps in touch regularly with the public health nurse who has been able to counsel her over a few rough spots.

V.W. is a married woman of 21, who was twice in hospital. The diagnosis was unspecified character and behaviour disorder—pathological lying — with borderline intelligence. She has been home for some months and seems fairly well, even though she and her husband live in a one-room shack, and our patient's mother is the common-law wife of the husband's brother. In this case, the public health nurse has had to assume an authoritarian rôle which this couple have been happy to accept.

Certain of our patients leave hospital still taking tranquillizing drugs. While we feel that drugs must be used as a crutch, to be discarded when the patient is well, it often seems that the crutch is needed for some time after his return. Stressful periods are the meetings with old friends and neighbors, returning to work, meeting his employer and fellow-employees, and returning to social organizations which he formerly enjoyed. We have found that the family physician will gladly oversee drug management, which includes recognition of secondary symptoms, dosage adjustment, and final discontinuance when it is no longer needed. The hospital will supply drugs, gratis, for a reasonable period when the patient is unable to purchase them.

Our present plan for "follow-up care" is made necessary by the distance between the mental hospital and the centres of population. The trends for the future are to have smaller hospital units in each population centre—200 to 300 beds closely attached to general hospitals, with increased community care, so that treatment can be given with the least dislocation of the patient.

Foreign Programs

Such programs have been reported from many centres[2]. In England, Nottingham Hospital with 1000 beds, all open wards, and nearly all admissions voluntary, provides out-patient psychiatric screening, whereby, if possible, the patient is treated in his own home. There are out-patient therapy centres, day hospitals, where the patient spends the night at home with his family, and night hospitals, where the patient can work during the day. Besides this, psychiatric beds are available in the general hospitals for acute illness or short-term care. For the senile and arteriosclerotic groups, home care is often made possible by "meals on wheels"—so the patient can be sure of one hot meal daily, and "linen-exchange"—clean linen in exchange for soiled.

The Amsterdam plan postulates that the rehabilitation of a mentally ill person can only be accomplished in society itself, and consequently a successful stay in society is the only valid test of any therapeutic endeavour[3]. Amsterdam is a city of 900,000, with 22 out-patient clinics and two psychotherapy centres. Three thousand adults are under supervision, mostly in their own homes, but some in foster homes. A new referral means an immediate home visit by the psychiatrist. He tries to adjust the social pressure to the needs of the patient—some patients must be freed from all social pressures, which means hospitalization, while others can stand just so much, and need aid —sometimes material aid is given, not as a dole or a bribe, but as a medicine—possibly clothing or money. Treatment of the patient with understanding and honesty, without showing fear or using force, with tension-reducing psychiatric techniques, has had a tremendous effect on the public in the interest of mental health.

A mental health program, reported from Kentucky emphasizes that the attitude of the family towards the patient returning home is often deplorable.[4] "I'm afraid of him—he acts crazy"—or "I won't live with a crazy person—she's been in the asylum." These may arise after an initial acceptance of the patient, or may arise from prejudices or be precipitated by economic, family, or social problems. The patient, while in hospital, must have education concerning the lines of conduct he must follow if he is to remain in the community. The hospital attitude towards the patient is that he is a healthy person who has, unfortunately, chosen unsuccessful methods for dealing with personal relations. The positive aspects of his personality must be emphasized with sincerity by the staff, which helps the patient to perceive himself as a worthwhile, strong individual, worthy of self-respect. But, this attitude must be shared by other persons and agencies in the community, including employers.

It is quite obvious that none of these plans can be carried out without the closest co-operation between mental health and public health personnel. Dr. E. G. McGavran points out that the total approach to mental health has been patient-centred, and while much good has been done to individuals, there must be a community-centred approach if there is to be prevention[1]. He mentions the tendency of our society to over-protect our children, citing progressive education, the emphasis on recreation rather than work, while work, he says, is one of the best physical and emotional stabilizers. He feels that we have built up a susceptible population, who are more likely to break down when exposed to conflict and trauma just as an unvaccinated person is likely to develop smallpox. Controlled exposure to stress could be explored and researched, and he suggests that this is an idea that holds hope for real control of mental illness.

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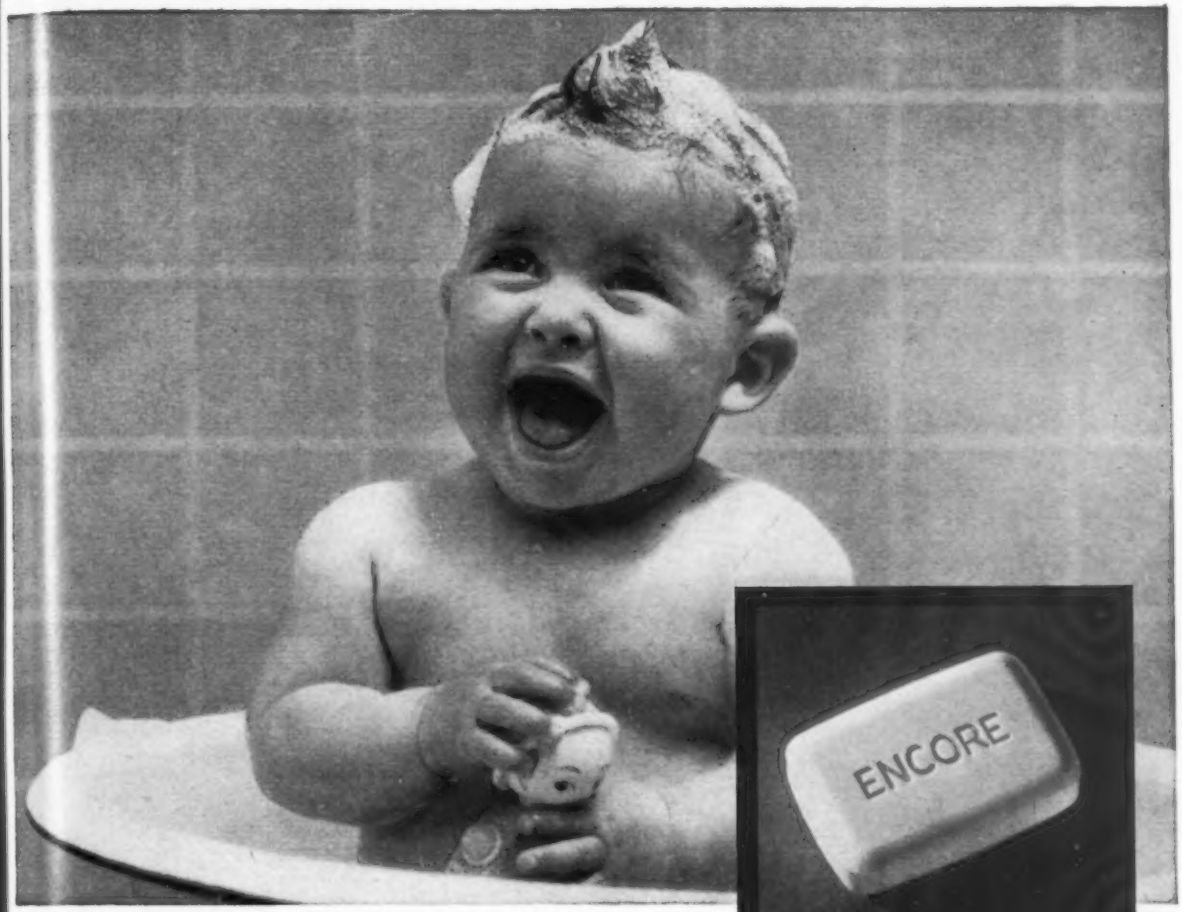

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Mental Disorder
(continued from page 49)

physiological functioning of the brain at the higher levels of functioning are slowly being unravelled. Particular interest is attached to those brain structures, the hippocampal and intralaminas systems, which seem to be concerned with emotional behaviour[8]. The connections between these systems and the cerebral cortex are crucial for the understanding of emotional reaction to stress and the great group of affective disorders.

The physical orderliness of the brain is the warranty of orderly psychological activity (in the sense of subject to laws of functioning). Current psychological researches are particularly concerned with learning theory, with the experimental psychology of stress, and with personality tests. Learning theory is of importance to the practices of psychotherapy[10] and to the understanding of motivation through affective experiencing[19]. Stress raises the issues of homeostatis and the equilibrium between psychological and physiological events[21].

Psychodynamic formulations are still more applicable to the problems of neurotic and psychosomatic disability than to the psychotic forms of mental disorder. But in the affective disorders and in the schizophrenias a rich material continues to stimulate study. Problems of communication, and of the management of regression and hostility recur as central themes of concern[5]. Such problems are more related to particular techniques and tend to have a marked individual quality. Research activities in this area have been mainly directed to the assessment of change[15].

The appraisal of benefit in more or less quantitative terms is a surprisingly difficult problem in any psychiatric intervention, particularly psychotherapeutic, whether in individual or group sessions. Subjective testimony cannot be altogether accepted and contrast with controls awaits on reliable personality tests. However the nature of personality tests indicates the increasing number of variables that combine to produce effects at this level of human functioning.

The variables are still further increased when the problems of social psychiatry are considered. Yet these problems demand very practical solutions. The variety of child rearing practices, the various interactions of family members, the emotional climate of a school, the consequences of differing kinds of organization in a business, or hospital, or other service. Studies and interventions in these areas are still crudely empirical[22] but not without rewarding possibilities. The salutory effects of "open door" policies in previously closed wards, the apparent effect of liberal arrangements for psychiatric treatment in general hospitals and developments of like kind illustrate the contrasting effects of rejection and isolation on the one hand and acceptance and communality on the other.

Many more areas of particular research endeavours in the field of mental disorder might have been mentioned. The effects of sensory deprivation and overloading, the field of child maturation and development, the statistical demographic studies that bear on aetiology, the inventiveness to improve techniques of treatment and the like. But enough has been said to show that empiricism and scientific process are beginning to conjoin in the psychiatric field, to their mutual reinforcement. Yet the promise of this poised situation will remain unfulfilled if research support is accorded only to achieve immediate practical gains. Psychiatry requires "experiments of light as well as of fruit"[16].

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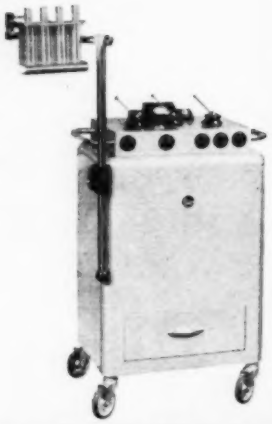

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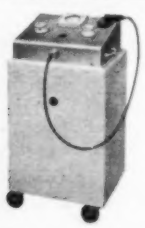

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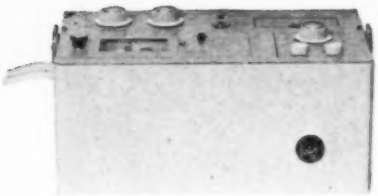

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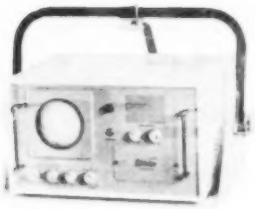

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Table No. 2

Re: The occupation of patients in 16 Ontario Hospitals with a resident patient population of 21,267 as of 1/1/59

Location and kind of Occupation or facility	No. of Hosps.	Number of Patients occupied (estimated) (actual) Men	Women	Total
1. Amusement hall	11	204		204
2. Baker shop	9	42		42
3. Canteen	6	12		12
4. Carpenter shop	10	27		27
5. Chicken pens	7	18		18
6. Central dining rooms	9	306		306
7. Corridors: offices: staff quarters	16	412	412	824
8. Cleaning wards	16	1095	1094	2189
9. Dairy barns	7	85		85
10. Farm	8	189		189
11. Greenhouses	8	54		54
12. General maintenance shops	11	63		63
13. Garden	15	366		366
14. Kitchen	15	97	97	194
15. Laundry	16	447	447	894
16. Lawns	15	169		169
17. Mattress shop	9	51		51
18. Mending room	11		117	117
19. Paint shop	14	107		107
20. Power house	7	24		24
21. Staff dining rooms	13		91	91
22. Sewing room	13		169	169
23. Shoe repair shop	7	25		25
24. Stores	13	61		61
25. Snow shovelling	15	445		445
26. Tailoring shop	5	15		15
27. Vegetable preparation room	13	57	58	115
28. Ward dining rooms or services	14	428	427	855
		4799	2912	7711

(continued from page 45)

or treatment-wise to maintain the hospital farms or to retain them for the treatment and rehabilitation of a predominantly urban, industrial and white-collar patient population. Similarly, in the laundries, trades shops and even in the care of the grounds, expensive mechanical equipment and highly skilled personnel are being provided to cope with the volume of work efficiently and satisfactorily. It is too costly and unsafe to have this equipment operated by other than very skilled personnel. Such equipment has resulted in the elimination of many of the worthwhile manual jobs which used to be available to patients.

These changes in treatment and rehabilitation concepts and procedures and in gross population are radically increasing the requirement for activity therapy—particularly work therapy. Conversely the change from an agricultural to an industrial and highly mechanized economy has resulted in a drastically diminishing range and number of occupations available for activity therapy.

This situation was sharply pointed up by an increasing number of unoccupied patients. The problem has been noted and studies have been inaugurated to determine what must be done, why, how and by whom, to provide adequate suitable opportunities for therapeutic work.

With regard to the provision of ordinary work activities, a review of a recent survey of the 16 Ontario provincial mental institutions gives us some indication of the present picture. This survey was conducted in January 1959 and deals with a total resident patient population of 21,267 in two hospital schools for retardates and 14 mental hospitals. In *table 2* the actual kinds and location of occupations available are listed in detail, with the number of hospitals where each is used and the number of patients so occupied.

A study of *table 2* reveals that many of these 28 kinds of occupation are so similar that there are in fact only four main kinds of work and that most of these offer unskilled manual work or heavy labour and the small remainder would at best offer semi-skilled work. Many of these jobs occupy only part of the ordinary working capacity of an individual patient because they are seasonal or part-time or periodic.

In *table 3* we have reduced the number of kinds of work to a realistic number of four. The total proportion of patients engaged in these is 36 per cent.

This indicates that the provision of the kind and amount of work opportunities is inadequate. In fact a similar report of 75 years ago refers to some 90 occupations and 52 per cent of the patient population being regularly occupied. A comparison of these two reports indicates a serious trend of diminishing work opportunities for patients. This trend is causing real concern and serious reconsideration of the potentials of work as therapy and the potentials of the hospital facilities in providing this requirement for work therapy.

The diminishing suitability of work opportunities available to patients in our hospitals is especially significant in view of the changing social and occupational characteristics of the population. As noted, the occupations now available for work therapy are essentially heavy labour and unskilled tasks. The realistic requirement for such therapy is vast and its provision requires investigation and constructive planning.

Until now, patients have been assigned tasks chiefly as a matter

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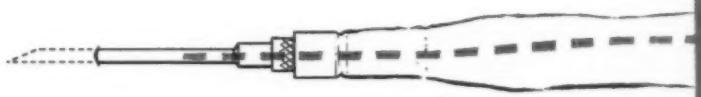

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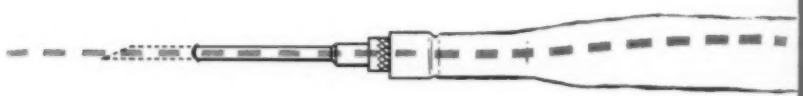

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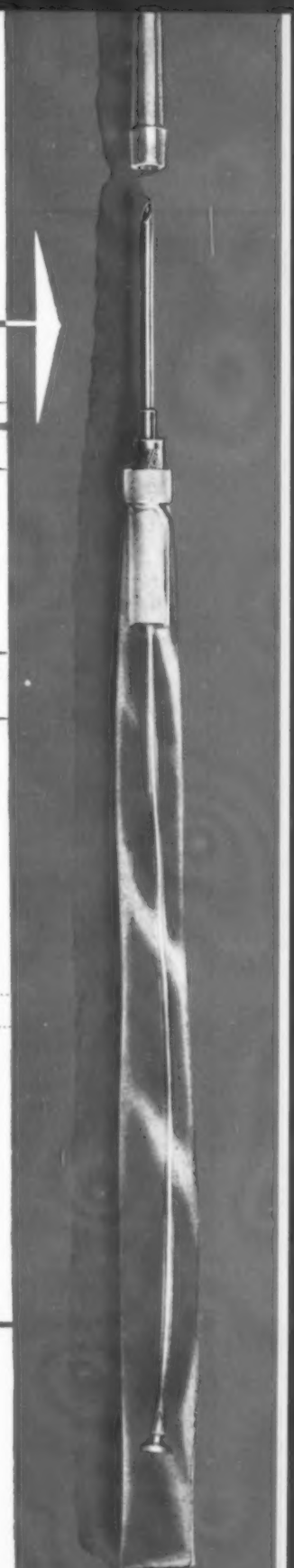

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of service. In the past there has been a minimum of supervision and almost no training or progression which could be related to or of value to rehabilitation. The staff under whom these patients work have received no orientation or training in treatment and rehabilitation.

Table 4 brings into sharp focus some very significant trends in our patient population, especially the increase of absolute numbers and the proportion of aged patients.

Recognition of this picture and this trend has resulted in a plan to realign our policies, objectives and practices with regard to work therapy, values and requirements, supervision, training and correlation in over-all rehabilitation planning. It is fortunate that the increase in the number of patients is really the only significant negative trend in our activity therapy picture. It is encouraging to know that the problems of reversing this trend are under consideration at the moment.

Occupational therapy and occupational therapy services *per se* are now available in 14 of Ontario's 16 provincial mental institutions. These services provide for the specialized use of activities for treatment and rehabilitation purposes and are staffed by approximately 36 occupational therapists and 120 occupational therapy assistants. The purposes of specific occupational therapy include: (a) amelioration of symptoms; (b) exploration of aptitudes and interests; (c) development of the patient's abilities in good interpersonal relationships and in work, recreational and social activities; (d) maintenance of existing skills not affected by the illness or disability; (e) development, redevelopment or maintenance of good work habits and work tolerance; (f) provision of motivation and "sub-industrial" level of training; and (g) assessment of function and work readiness.

In occupational therapy many kinds of activity are used and adapted to the needs of individual patients in a progressive plan of treatment and rehabilitation. Occupational therapy is most effective when it is directed by a psychiatrist and closely correlated with all the other treatment and rehabilitation services required by each individual patient.

In addition to qualified occupational therapy personnel, there is a growing trend toward the use of people with specific training and/or skill in any given activity to provide that part of the program under supervision.

As previously mentioned, we have activity therapies such as music,

Table No. 4

Re: Characteristics of the patient population as of January 1, 1959 (estimated)

Age spread	0—14 years	15—24 years	25—64 years	65 yrs. & over*	Total
Number	1638	1914	13143	4752	21267
Percentage	7.7%	9%	61.8%	21.5%	100%

*Statistics indicate that both the proportion and numbers of this group are increasing more rapidly than other age groups i.e. in 1941 there were in Ontario Mental Hospitals, 1788 patients, in 1957—4529 patients, and in 1959—4752 patients, 65 years of age and over.

Disability grouping	Mental Retardates	Psychoses, neurosis, epilepsy and addiction	Senility Arterio Sclerosis	Total
Number	6380	12760	2127	21267
Percentage	30%	60%	10%	100%

Table No. 3

Re: The main kinds of occupation and the numbers of patients working part or "full time" in 16 Ontario Hospitals as of January 1, 1959.

Kind of Occupation or Facility (as per items in Table No. 2)	Number of patients occupied (Estimated Proportions)		(Actual)
	Men	Women	Total
Housecleaning—including items 1:7:8	1711	1506	3217
Farm and grounds — including 5:9:10:11:13:16:25	1326	0	1326
Maintenance shops—including items 4:12:15:17:18:19:20:22:23:24:26	820	733	1553
Kitchen and dining services—including items 2:3:6:14:21:27:28	942	673	1615
	4799	2912	7711
Percentage of the total (21267) resident patient population	22%	14%	36%
Percentage of patients who are occupied part time to "full time" in activities provided through the occupational therapy services is estimated at			24%
Total number of patients occupied in any designated "work" activity			60%

art and recreational therapy. At present, when the particular therapy is headed by a person who is suitably qualified, this special therapy usually retains its identity. Otherwise, the worker and the activity are generally incorporated in the over-all organization of the occupational therapy service.

Needless to say, the number of trained personnel and the extent of the facilities are very inadequate in relation to the existing needs for occupational therapy *per se*.

And what about volunteers? Within our hospitals in the past few years, a variety of recreational, technical and welfare services have been contributed by volunteers. These have had particular worth in extending and enriching the activity programs for patients in hospitals; and have provided valuable community links in the socio-economic adjustment of patients. The trend toward increasing volunteer participation is part and parcel of the essential trend toward closer relationships between the community at large and the mental health services.

Further development of modern concepts of activity therapy will depend on research and improved education and training of personnel, and the progressive development and correlation of all the available resources of the hospital and the community. More and better trained personnel are urgently needed. ■

Institute on Methods Improvement

An Institute on Methods Improvement, conducted by the American Hospital Association and sponsored by the Ontario Hospital Association, will be held in the Royal York Hotel, Toronto, Ont., February 29th to March 2nd, 1960. The purpose of the institute is to help stimulate interest in and an understanding of the need for organizing methods improvement activities in hospitals, to analyze the approaches to initiating and maintaining an organized program, and to provide specific information on some of the tools of industrial engineering which are applicable to hospitals. Applications should be sent to The American Hospital Association, 840 North Lake Shore Drive, Chicago 11 Ill.

Another activity planned by the Ontario Hospital Association Committee on Education is the second in a series of three one-day institutes on Hospital Nursing Service to be held in London, Ont., February 16th, 1960.

Diets and Dyspepsia

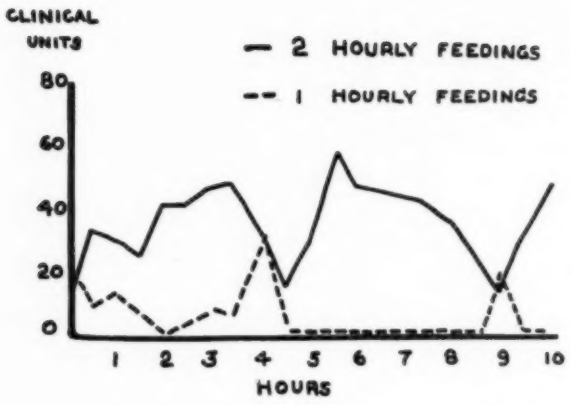

Figure 1

Part II

J. R. Bingham,
M.D., F.R.C.P.(C)
Toronto, Ont.

BEFORE turning to the use of diets in the individual diseases of the digestive system, it would be well to recall the three functions of a diet—the nutritive, the physiological and the psychological. In the following discussion these will not be described separately and one or more may be omitted. This does not indicate any lack of importance but rather the desire to confine the discussion to principles rather than details.

Peptic Ulcer

The patient with peptic ulcer may require treatment either for acute ulcer pain or for one of the complications of ulcer such as pyloric obstruction, subacute perforation into the surrounding tissue, or haemorrhage. Free perforation is a surgical emergency and does not concern us.

The dietary regimen for these various disorders is, fortunately, the same. It is based on frequent feedings planned to produce maximum neutralization of gastric acid.

When the patient has a low dietary tolerance, which occurs with severe pain, anorexia, nausea, or vomiting, hourly feedings of skim milk, whole milk, or cream are prescribed. When the tolerance improves the "basic" diet is superimposed on the hourly feedings of milk.

Following haemorrhage appetite returns quickly and the patient usually has a good tolerance for food. Meulengracht prescribes beef steaks and other high protein foods but this extreme view on diet is not generally followed. The "basic" diet with hourly milk feedings is quite satisfactory.

The milk is given at hourly intervals to lower gastric acid and to encourage healing. Figure 1 shows the good reduction of gastric acid when milk is given hourly compared to the poor reduction of acid when milk is given every two hours. The rise of acid at the 4th and 10th hour of the hourly feedings was due to psychological stimulation of gastric juice when the patient saw others eating their meals. This "appetite juice" should have been controlled by satisfying the patient's hunger by adding cream to the milk.

Mention must be made of the growing tendency among gastroenterologists to dispense with special diets in the treatment of peptic ulcer. The author permits most ulcer patients whom he treats in the office to eat anything they fancy.

Celiac Disease and Non Tropical Sprue

Celiac disease and non tropical sprue may be the same disease occurring at different ages; the former is found in childhood, the latter in adulthood. Their cause is unknown. The villi of the small bowel are blunted and flattened which results in a great reduction of absorbing surface. Whether this reduction in the absorbing surface of villi is the cause, or the result, of the disease is undecided.

Patients with these two disorders have poor absorption of fat and increased loss of fat in the stool (steatorrhea). They also have poor absorption of protein, carbohydrates, vitamins, minerals and water.

The introduction of gluten free diet by Dicke in 1950 marked a great advance in treatment[5]. Gluten, or wheat germ, is the insoluble protein constituent of wheat and other grains. The mechanism by which gluten causes steatorrhea is unknown. Perhaps it is due to the absorption of food products which are not normally absorbed. For instance, if patients with celiac disease are given a loading dose of gliadin, (a fraction of gluten), the blood glutamine rises[6]. This glutamine is in the form of a glutamine containing peptide and as you know, peptides are not normally absorbed.

In a gluten free diet the following foods should be avoided:

1. Bread, rolls, dumplings, pancakes, waffles, pastry, cake, cookies, biscuits, soda biscuits and arrowroots.
2. All cereals except rice krispies and puffed rice.
3. Canned cream soups, or those with noodles, or barley. Clear soups with rice are allowed.

Dr. Bingham is an Associate in Medicine, University of Toronto, and an attending staff physician at the Toronto Western Hospital. This paper was presented to the Dietetic Section of the Ontario Hospital Association at the convention held October, 1959.

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4. Spaghetti, macaroni, vermicelli and noodles.

5. All candy except home-made candy which has no flour or starch added.

6. Sauces or gravies thickened with flour or cornstarch. Soya flour is an excellent substitute.

7. Malted milk, yeast cakes, chewing gum.

8. Meat loaf using bread crumbs, bologna, sausage, frankfurters and bread dressing.

9. Commercial catsup, tomato sauce, prepared mustard, mayonaise, salad dressing, et cetera. Home-made products with no flour or starch added may be used.

Idiopathic Ulcerative Colitis

The organisms of amoebic and bacillary dysentry cause a small percentage of the cases of ulcerative colitis; however, 95 per cent of the cases have no known cause, and are called "idiopathic." Because the etiology of idiopathic ulcerative colitis is unknown, treatment is unsatisfactory. Treatment consists of steroid therapy, psychotherapy and general supportive measures.

The entire colon may be covered with ulcers and resemble raw beefsteak yet the patient may tolerate a normal diet with a normal amount of roughage. The author starts treatment with the "basic" diet already described and then adds other foods as tolerated.

Functional Colon Disorders

The functional colon disorders are the commonest disorders of the digestive system. They are characterized by the physiological or functional derangement of colon motility and secretion as opposed to the structural abnormality seen in diseases such as ulcerative colitis. The cause of the altered colon motility and secretion is psychological. The patient may suffer from constipation, diarrhea, mucus or pain either singly or in combination. The pain can mimic any abdominal disorder, and an uncountable number of appendices, gall bladders, ovaries and uteri have been removed in the misguided attempts to cure this disease.

Patients suffering from a functional disorder of the colon may observe that certain cereals and vegetables increase their symptoms. Analysis reveals two causes; but only one operating at a time. The first is a reaction to roughage in the diet which causes hyperperistalsis and spasm of the colon from irritation of the bowel. Patients with this reaction have increased symptoms with salads, celery and other indigestible cellulose foods. The second cause of symptoms is starch intestinal fermentation already described. Patients with this reaction are not troubled by indigestible cellulose foods but rather by the starches of poorly cooked vegetables and cereals.

The main treatment of functional colon disorders is psychosomatic; however the patient can frequently be helped by a simple adjustment of the diet according to the principles already outlined.

Pancreatitis

The symptoms of acute pancreatitis are caused by the escape of the pancreatic ferments from the pancreatic ducts into the surrounding tissue where they produce a necrosies of pancreatic and other tissues. How these powerful enzymes escape from the ducts is unknown.

The treatment of pancreatitis is to control the production of pancreatic ferments. These ferments are under the control of both the vagus nerves and the hormone *secretin*. The vagi are stimulated by hunger, and the sight, taste and

smell of food. *Secretin* is formed in the mucosa of the upper small intestine when food leaves the stomach. It reaches the pancreas by the blood stream where it incites the production of pancreatic juice. Food is used in two ways to reduce the production of pancreatic juice and to maintain a low even rate of production. The first is to reduce vagal stimulation by eliminating hunger and the second to reduce *secretin* formation. Both are accomplished by the administration of frequent small feedings of food chosen from the "basic" diet.

Gall Bladder Disease

The most effective stimulus for contraction of the gall bladder is the presence of large amounts of fat in the intestine. Because of the stimulating effect of fats, gall bladder attacks frequently occur after a heavy meal.

The diet of choice in the treatment of gall bladder disease is one which avoids heavy meals and fat. Therefore, in acute cholecystitis, or in biliary colic, the diet would consist of sugar and carbohydrate drinks. When the acute stage of the disease has passed, frequent small feeding of the basic diet is satisfactory.

Acute Hepatitis

The dietary treatment of acute hepatitis and hepatic failure has changed greatly over the last three decades. The high carbohydrate diet introduced by Jones in 1936[7] gave way to the high protein diet of the 1940's which, in the 1950's gave way to one containing more normal amounts of protein and fat. In carefully controlled experiments on soldiers during the Korean war, Chalmers and his group[8] demonstrated that the best diet in hepatitis is one containing 3000 calories and approximately 150 grams of protein and of fat.

Laennec's Cirrhosis

In Toronto 90 per cent of Laennec's cirrhosis is caused by chronic alcoholism and malnutrition. Whether the cirrhosis is caused by a secondary or conditioned dietary lack due to the substitution of "good" food (protein) by a "poor" food (alcohol) or whether alcohol has a direct toxic effect on the liver is an undecided question. In either event, the ingestion of a well balanced diet is essential if the patient is to recover.

During the stage of anorexia the patient may tolerate little else than fruit juices and coffee. At this stage the patient should be given whatever he thinks he can eat. When anorexia passes the "basic" diet may be useful and this may be followed later by the diet prescribed for hepatitis.

When ascites is present restriction of salt is advisable. However, restriction of salt should not be at the expense of palatability. It is better to eat food with a little salt than to eat no food at all.

When hepatic coma is impending, protein must be drastically reduced. The failing liver is unable to convert the ammonia from protein metabolism to urea. Ammonia then rises in the blood and spinal fluid and coma may be precipitated.

Summary

In summary I wish to stress two points. The first is to remind you that if maximum benefit is to be obtained from a therapeutic diet for the treatment of gastrointestinal disease the diet must fulfill its three functions—the nutritional, physiological and psychological. The second point is a plea for simple diets. There is no need for

a different diet for each different gastrointestinal disease. You have seen how the simple "basic" diet, with minor modification, may be used for the treatment of most gastrointestinal disorders.

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Community Services

(concluded from page 51)

be required if available resources are to be used most effectively

In the years ahead, it can be expected that additional psychiatric facilities will be introduced in the community. One can also anticipate further modifications in the services which the mental hospital provides. Developments in these two types of psychiatric facilities have in the past, tended to move forward along separate and divergent paths. With increasing recognition that hospitalization, when required, represents but one phase in the treatment of a mental illness, a greater degree of unity can be expected in the patterning of mental health services. Whatever facilities are employed, it is essential that the mental health services be organized in such a way that a continuum of care can be provided so that the advantages of early recognition and prompt treatment of mental disorders will not be lost to the patient.

Increased understanding of mental illness, and improvements in treatment methods present challenging opportunities for the organization and patterning of mental health services. In Ontario, a number of new types of psychiatric facility have appeared in the community. Elsewhere, developments have centred around the mental hospital which, by extension of its services, has been able to meet most needs for psychiatric assistance in the community.

Current concepts of care are directed towards the management of the patient in the community, and towards this end efforts are being made to integrate and coordinate the various types of services. Recognition is given to the special needs of children.

Diagnostic and treatment services are considered the framework of a community mental health service. Supportive services for building and protecting mental health, and an on-going educational program are two other essential elements.

General lack of concern for the problems of mental illness is seen as the greatest single obstacle to be overcome. In the patterning of services in the future it is important that provision be made for a continuum of care so that the advantages of early recognition and prompt treatment are not lost to the patient. ■

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A.C.H.A. Activities

Harold J. Leavitt, professor of industrial administration and psychology, Graduate School of Industrial Administration, Carnegie Institute of Technology, Pittsburgh, was granted the College's 1960 hospital administrator's award for his book *Managerial Psychology*. The award, which includes a $500 cash prize, was presented to Professor Leavitt on February 5 at the third annual congress on administration by James A. Hamilton, director and professor, course in hospital administration, University of Minnesota. Mr. Hamilton is chairman of the congress book award committee.

The hospital administrator's award is granted annually during the College-sponsored congress to the author of an outstanding book on hospital administration. The 1960 award was the third to be granted. Earlier winners were Herbert A. Simon for *Administrative Behaviour* and Chris Argyris for *Personality and Organization*. There are five judges in addition to Mr. Hamilton on the book award committee. They are Col. F. H. Gibbs, director, program in hospital administration, The George Washington University, Washington, D.C.; Professor Herluf Olsen, Amos Tuck School of Business Administration, Dartmouth College, Hanover, N.H.; Professor Royal S. Van de Woestyne, School of Business, University of Chicago; Professor Edward T. P. Watson, School of Business, Northwestern University, Evanston, Ill.; and Dr. Charles U. Letourneau, executive editor, *Hospital Management*, Chicago.

Also commended at the third annual congress was Father R. J. Henle, Professor of philosophy and Dean of the Graduate School, St. Louis University. He won the article award competition with *The Intellectual Development of the Operationalist*, published in *Hospital Progress* in May 1959. Honoured, too, was a Canadian, Professor Oswald Hall of the University of Toronto. He was the first winner of the Edgar C. Hayhow Award, for his article *Motivation and Morale* which was published in the summer issue of *Hospital Administration*, the quarterly journal of the College.

The College is co operating with the department of hospital administration at the University of Minnesota in another project. A week-long basic institute for hospital administrators is scheduled in Minneapolis between February 22 2[illegible].

German Hospital Congress

The second German Hospital Convention, with its exposition "Your Hospital", will be held in Stuttgart from the 18th to the 22nd of May, 1960. The comprehensive exposition, which will be prepared and conducted by the Stuttgarter Austellungs GmbH, will occupy all the buildings of the Killesberg Exposition Grounds in Stuttgart. It will show such goods as are produced by industry to assist the hospitals in modernizing their equipment and rationalizing their methods.

The first exposition "Your Hospital" was organized in conjunction with the first German Hospital Convention in Cologne in 1958. Over 400 exhibitors were represented.

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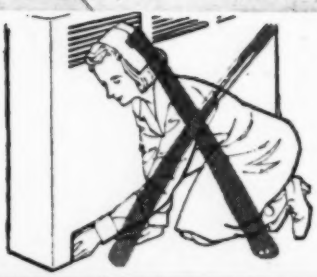

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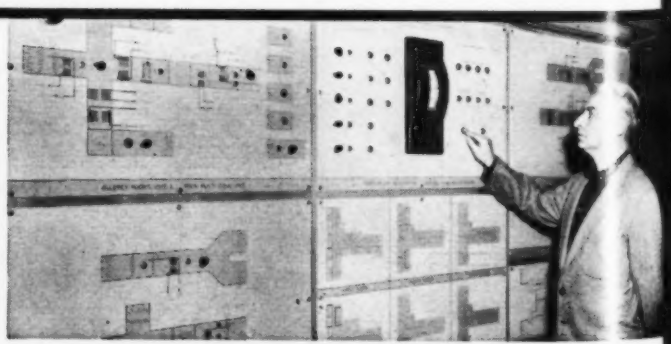

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What do Statistics Show?

(concluded from page 38)

cent for females. For psychoses alone, the expectations of admission are: at birth—4.6 per 100 for males and 5.6 for females; and at age 25—4.4 for males and 5.5 for females.

A decline in the first-admission rates to mental hospitals in the future would, of course, be reflected in lower expectations of admission.

Psychiatric Units

Since 1948 a total of 351 beds have been set aside for the diagnosis and treatment of mental disorders in eleven public hospitals throughout the province. During 1958 a total of 4,364 patients were admitted for treatment to the eleven psychiatric units of public hospitals in Ontario; of these 1,069 were readmissions. Female patients in these units outnumber male patients in the ratio of 1.6 to 1. The median length of stay of patients in these facilities is 20 days. Over 85 per cent of patients discharged return to their own homes; less than 9 per cent are recommended for transfer to a mental hospital.

Mental Health Clinics and Out-Patient Facilities

A total of 21,294 patients attended the 31 community mental health service facilities reporting to the Department during the year 1958; this is an increase of 1,852 over 1957. Of this number, 17,203 were new patients compared with 14,411 in 1957. In providing diagnostic and treatment services the staff of all reporting clinics and out-patient departments conducted a total of 129,388 interviews.

The 21 services reporting case load in detail to the department had a total case load of 13,949 of which 8,393 were new cases. A total of 9,313 cases were terminated during the year.

The case load in these auxiliary mental health facilities has increased in recent years as their number and capacity has increased.

The Future

We should not be misled by any temporary decline in the mental-hospital patient population: unless there is some unforeseen change in the incidence of disabling mental illness, some change in admission policy, some cure not now available, or substantial decline in the average length of stay, admissions and total case load (even with relatively stable admission rates) will continue to increase in absolute numbers, and further increases in bed capacity (especially for mental defectives) will be required.

Ontario's population is growing at the rate of nearly 200,000 persons annually, or 3 per cent per year. The older age groups, 65 years and over, now comprise 8.1 per cent of the population and will continue to grow in numbers though declining in proportion to the total. If the present admissions and discharge rates are maintained much as they are, an annual increase of at least 600 in the number of mental hospital beds in Ontario will be required to keep pace with the demand for facilities. ■

Extension To B.C. Cancer Foundation

The estate of the late George F. Laing of Vancouver made a bequest of $583,000 to the B.C. Cancer Foundation. This will mean considerable extension of facilities, including two new floors to be added to the B.C. Cancer Institute and a new solarium. A new colbalt-60 unit is to be bought and a third is contemplated. The sum of $30,000 is to be donated to the clinic in Victoria and a cobalt unit purchased.—*C. M. A. Journal.*

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Changing Mental Hospital

(continued from page 41)

whole field of medicine and its allied fields, but it has also improved the status of the mental hospital. This development has contributed significantly towards the acceptance of the mental hospital as a centre of medical treatment.

Developments along research lines have been important to the modern mental hospital. Important research studies have already made significant contributions to psychiatric knowledge, and all the evidence points to important progress in research in the future. This development has attracted to psychiatry many workers from the fields of endocrinology, neurology and all aspects of internal medicine, as well as those from the basic sciences of biochemistry, physiology and genetics. This too has played its part in creating the new kind of mental hospital.

Community Relationship

It can be stated unequivocally, that all the evidence available at this time bears testimony to the fact that attitudes and active participation of the community in the life of the hospital play a significant rôle in helping the patient. In the case of the mental hospital, the community's acceptance of mental illness, and their participation in the hospital program, has contributed significantly to the creation of the therapeutic milieu. This has been expressed in a very practical way by the appearance of volunteer workers, who have come willingly to the mental hospital to work with and for the patient, integrating their efforts into the fabric of the total therapeutic program. This development has had considerable psychological impact on the patients in the mental hospital. It has not only enabled them to come into contact with the community through volunteer workers and to develop feelings of acceptance and self-recognition, but it has helped to reinforce the patient's notions of the hospital as being a place of help. Volunteers have not only been active in organizing and participating in many types of programs and activities, but have also played an important rôle in correcting the misconceptions and fears which have been associated with mental illness for many years.

Extension of the Mental Hospital into the Community

A development which has attracted considerable attention is concerned with the treatment and management of the mentally disordered in the community. The Worthing experiment in England has provided rather impressive evidence to support the notion of community treatment for the psychiatric patient—both from the point of view of economics and the beneficial effect on the patient. Briefly, the aim of the Worthing study is to keep as many patients as possible out of the hospital and, in order to accomplish this, the program is organized on three levels:

1. Establishment of domiciliary service, in which patients are visited by the psychiatrist in their own homes, and then treated there or in an out-patient setting.
2. The setting up of a psychiatric out-patient department in a general hospital.
3. A day hospital and treatment centre—where somatic, psychotherapeutic and milieu methods of treatment are used.

This approach, according to the study, has reduced the admission rate to the mental hospital by a very impressive number.

The Amsterdam Plan in Amsterdam, Holland, also emphasizes the value of domiciliary and out-patient treatment, not only in reducing mental hospital admission, but in providing effective therapy. In the plan, psychiatric teams are organized in the community to de-

with psychiatric problems as they arise.

An interesting report from New York describes an emergency psychiatric service operating within a general hospital setting. This also has proved extremely effective in dealing with acute psychiatric problems.

These developments, although based on the community, have important implications for the modern mental hospital—in terms of its status, rôle and purpose in the overall approach to psychiatric problems. It is likely that this more recent trend will involve mental hospital staff to a major degree—as it did in the Worthing Experiment.

In this paper, we have directed our attention to the changing mental hospital. Basically it refers to the development of facilities, staff and an approach which takes into account the hospital and all it embraces, and it recognizes this as having an important therapeutic potential. The effective utilization of all those techniques and modalities which potentially have the capacity to raise the patient's level of functioning, help in altering ineffectual modes of thinking and relieve paralyzing emotional attitudes, must be the primary approach. No longer can we consider the mental hospital merely as a repository for people exhibiting socially disturbing behaviour. Now, the mental hospital is seen as a place which provides the medical techniques and human approaches necessary to restore patients to their highest possible level of health. For many patients this means return to their family, friends, work and community. For other patients, it means more effective functioning, and living within the shelter of the hospital.

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Curiosity is one of the permanent and certain characteristics of a vigorous mind.—*Samuel Johnson*

Pension Plan

A comprehensive pension plan, enrolling some 7,000 employees from 54 hospitals in Ontario, became effective January 1, 1960. For most of the employees enrolled, it will be the first opportunity they have had to be covered under a pension plan. The Hospitals of Ontario Pension Plan, sponsored by the Ontario Hospital Association, is a contributory plan to which hospital employees will contribute five per cent of their earnings while the hospital contributes the balance of the cost to provide employees with both past service and current service pension. The portability feature of the plan will enable employees to transfer their benefits from one contributing member hospital to another. In addition, employees coming under the plan will receive recognition for their past service with their employing hospitals.

Psychiatric Service

(concluded from page 55)

we spread ourselves too thinly. If we restrict our activities to doing more and more intensive therapy, very few patients will be seen during the course of a year. In this setting, staff must learn to adopt realistic goals and, in attempting to achieve these goals, must serve the greatest number with the best treatments which are available. We find that one team can carry a case load of about 160 people from month to month. Some of these are being seen weekly or even more often and some cases only monthly for supportive therapy or supervision of medication. Intake procedures allow the admission of about 30 new cases a month. The Peterborough clinic does not have any geographic boundaries such as the city or county limits. Cases are referred by more than 100 doctors and agencies, some of which are about 100 miles distant from the clinic. About one-third of the cases are not residents of Peterborough.

People must be helped to understand that a breakdown in emotional health does not just happen. The assessment of conditions which contribute to an illness may require several hours of investigation, often to be followed by many hours of treatment over a period of months. As more individuals come to know and understand clinic methods and our special problems, more satisfactory referrals will result and the treatment process will be made easier, with more likely recovery of our patients.

The follow-up studies undertaken over the past few years from this clinic have shown that a majority of patients do improve considerably and that, in the large majority of cases, our recommendations are followed by treatment here or by other means. We feel that this suggests a realistic use of the clinic by the community and indicates that it is an accepted and useful part of the medical facilities provided for the doctors and their patients in this district.

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Could Be!

Those "crazy drivers" you meet on the highway may be just that! The Psychiatric Institute of Chicago's Municipal Court has found that 40 per cent of traffic violators require psychiatric treatment.

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the participation of staff psychiatrists as colleagues on hospital committees and boards.

There are those who claim that the units have helped to break down the prejudice and misunderstanding over mental illness held by the general public. Certainly it appears that patients (and sometimes the community) attach less stigma to being cared for in a psychiatric unit than in a mental hospital.

In some localities the general hospital unit is the only in-patient facility in the area. It has made it possible for patients to receive treatment near their homes with less disruption of family and occupational ties than would have resulted from admission to a mental hospital. In most psychiatric units it is often easier to arrange for continuity of care between in-patient and out-patient services and for psychiatrists in private practice to maintain contact with and care of their patient during and following an episode of hospitalization.

Most leaders in the field of medical education support the view that psychiatric units have made a positive contribution by providing training facilities for undergraduate nurses, medical students, psychologists and post-graduate students of psychiatry. Whether this opportunity is inherent in the general hospital setting or merely a by-product of the university emphasis in their settings is a moot question.

One of the earlier criticisms of the psychiatric units seems unsupported by experience, namely that general hospitals, by treating most of the acute psychiatric illnesses, would cause mental hospitals to become centres for the care of chronically ill, "hopeless" cases. So far there is no evidence that this is happening. Conversely, and unexplained, is the observation that the general hospital units do not appear to have lowered the admission rates to mental hospitals. More valid criticisms are that most general hospital units have such small numbers of patients at one time that they are limited in the diversity of special therapeutic facilities for certain groups of patients. Another limitation imposed more and more, with government insurance plans, is a tendency to enforced time limitations which may not be consistent with the best periods of treatment for some patients.

An argument that recurs locally with the introduction of each new unit is that hospital boards, administrators and nursing officers find it difficult to incorporate the radically different techniques of therapy and nursing care for psychiatric patients. These include nurses spending time participating in social and recreational activities, passes for visits of patients outside hospitals, or special records facilities. These problems rarely exist once the unit has been in operation and often certain approaches, such as occupational therapy, routine in the psychiatric department, are spread beneficially to other parts of the hospital. Bennett recently outlined the experience of many general hospitals in establishing and maintaining psychiatric units and found but few that would dispense with a psychiatric unit once it is established.[4]

The Future

It is likely that the general hospital psychiatric unit in its present typical form is a transitory phase. Many social changes in the provision of medical care are afoot and some of these are meeting "head on". Care of those with mental illness has long been look-

ed upon as a state responsibility with complete medical care of the patients being subsidized by public funds. Recently many psychiatrists have been going into private practice and accepting general hospital staff appointments, only to find that the rest of medicine is caught up in an evolution toward greater government participation — in hospital insurance plans, in medical care for children and in illnesses such as tuberculosis, cancer and poliomyelitis. From this ferment patterns are emerging which, some mental health administrators think, indicate that neither the small psychiatric unit nor the large mental hospital will survive as the principal locus of hospital care. Instead there will be a combination —the community psychiatric hospital of 200 - 400 beds nearby and associated with medical centres. These psychiatric hospitals will be separately administered and have fiscal arrangements which will permit adequate periods for appropriate treatment of all psychiatric disorders but they will be staffed and operated to retain the obvious advantages that the psychiatric units have demonstrated.

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Fear: Disease of the Atomic Age

Although there are some aspects of the fear of atomic power which appear to be equally characteristic of the dread of many other agents deemed to be noxious, the phenomenon seems to have qualities and mysteries which are peculiar to itself. Thus, the risk of being killed in an automobile accident, which is immediate and visible, and the danger from tobacco, which is delayed, both appear as much more real and credible threats than the dangers of radiation. Yet most people continue to drive and smoke without apprehension. It has been suggested that the peculiar qualities of radiation are that it is invisible, unheard, unsmelt, untasted and unfelt, apparently infinitely powerful, yet springing from an almost infinitely small source, and —as far as the individual is concerned—uncontrollable.

Of all the fears rising from radiation, whether it be from atomic bomb fallout or from nuclear plant mishap, it is the danger to food which is generally the most disquieting. In a reactor accident at Windscale, it was the danger to milk supplies that startled the public most of all. As with feeding, so with excretion. Public concern with atomic waste disposal is quite out of proportion to its importance, from which there must be a strong inference that some of the fear of fallout comes from a symbolic association of atomic waste with body waste.

It is out of this tendency toward regression that the more deeply irrational hope and fears and exaggerated emotional response will grow.—*World Health.*

BOOK REVIEWS

A STUDY ON THE NONSEGREGATED HOSPITALIZATION OF ALCOHOLIC PATIENTS IN A GENERAL HOSPITAL, by Mark Berke, Jack D. Gordon, Robert I. Levy and Charles B. Perrow. Hospital Monograph Series No. 7, American Hospital Association, 840 North Lakeshore Drive, Chicago 11, Ill. Pp. 50.

This paper back pamphlet reports on the experiences of one general hospital, The Mount Zion Hospital and Medical Centre of San Francisco, Calif., in providing treatment for the alcoholic patient on the general medical wards. One of the reasons for carrying out this study arose from the difficulties of interested health authorities in the state of California in attempting to interest a number of general hospitals in admitting the alcoholic patient for treatment. It was realized that there was considerable reluctance on the part of hospitals to accept such patients, fearing that they presented a special problem in ward management.

This report includes discussion of attitudes of nursing personnel prior to carrying out a program of treatment of alcoholics, as well as the attitudes of the same personnel following a period of training and actual treatment of alcoholic patients on their wards. There is a description of the medical management of these cases as carried out in this particular hospital.

It would appear that the greater emphasis in planning the treatment program must be directed towards the attitudes and expectations of the staff, rather than providing any unusual facilities for dealing with the alcoholic patient.

This booklet will be of interest to every physician who has encountered skepticism and experienced frustration in his attempts to have the alcoholic admitted to the local general hospital. It might well be considered "must" reading for the medical superintendents and administrators of our general hospitals.—*John D. Armstrong, M.D.*

Not many sounds in life exceed in interest a knock at the door.—*Charles Lamb.*

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Staff work is lightened; trays are lighter, easier to carry; number of kitchen trips is reduced; kitchen clean-up done in half the time.

Write now for details of this new and colorful Dixie Matched Food Service and valuable Hospital Case History Book.

NOT ALL PAPER CUPS ARE

DIXIE CUPS
T.M.R.

JUST THE BEST ONES

Bright, cheerful, colorful, the new Dixie Matched Food Service brightens and cheers up patients at meal-times. Protects against cross-infection ... always hygienic.

T.M.R. DIXIE CUP CO. (CANADA) LIMITED, BRAMPTON, ONTARIO

Care of the Mentally Ill

(continued from page 36)

Whitby	1920
Fort William (transferred to new and greatly expanded facilities in Port Arthur 1954)	1936
St. Thomas	1946
Aurora	1950
Smiths Falls	1951
North Bay	1957

As the foregoing shows, the ever present problem of overcrowding has existed from the beginning. In the attempt to meet the increasing need for patient accommodation, a variety of buildings built for other purposes were occupied temporarily or taken over for permanent use. The most recent examples of conversion are the Ontario Hospital, Aurora, formerly De La Salle College, taken over in 1950, and Beck Memorial Sanatorium in London, which is currently in the first phase of a three-stage transfer to provide accommodation for the Psychiatric Research Institute for Children.

The mental institutions built specifically for the purpose have shown radical architectural changes related to four eras. Those erected in the last half of the 19th century were in the famous "Kirkbride" style. One, the Ontario Hospital, Whitby, built during World War I, resembles a small community with detached cottages. The remaining four, built just before and after World War II, and recent large additions to older hospitals, are sprawling establishments characterized by large areas of glass, tile, terrazzo, stainless steel, and by long corridors. A new architectural phase is now beginning, with the designing of smaller regional hospitals.

The provision of separate accommodation for different categories of patients began in 1872 with the erection of a building to house mentally defective patients. Now, separate accommodation is provided also for epileptics, the tuberculous mentally ill, and the criminal insane. The purchase of Thistletown Hospital in 1957 provided also a special centre for the care of children with a variety of emotional and mental disorders.

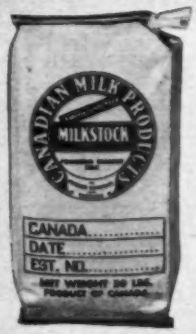
(to be continued next month)

NOTE: It is regretted that for lack of space three other articles which were prepared for this symposium must be held for a subsequent issue. Those yet to come are: *Legislation and Mental Illness* by Kenneth Gray, Q.C., M.D., *The Volunteer in Psychiatric Service* by F. A. Perretz; and *The Research Institute for Children at London, Ont.*; as well as Part 2 of the above article.—*Edit.*

Borden Guide to better food purchasing

BORDEN'S TRUMILK. Whole milk, cream and all, in handy, powdered form. Add 7 parts water to 1 part Trumilk by weight. No refrigeration needed.

BORDEN'S BREADLAC. Spray-process skim milk powder specifically designed for baking. Actually increases yield and quality of baked goods at no extra cost!



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Less storage space required!
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BORDEN'S POWDERED LEMON JUICE. 1 lb. equal to the juice of 48 freshly squeezed lemons. Labour-saving and economical for pies, tarts, fillings.

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Kennedy Agencies, 37 Highfield Street, Moncton, N.B.

McKenzie Stephenson Ltd., 345 Higgins Ave., Winnipeg, Manitoba.

Kirkland & Rose, (I & A) Ltd., 130 Water Street, Vancouver, B.C.

Provincial Notes
(concluded from page 66)

chapel is non-demoninational. Each denomination conducting services in the chapel will supply its own religious symbols which will be kept in a cupboard in the room. At one end of the chapel is a family room which may be used for consultation or as a waiting room.

British Columbia

Following a survey by the Toronto hospital consultants, Agnew, Peckham and Associates, the board of the Vernon Jubilee Hospital, Vernon, has announced that architects Smith and McCulloch of Vancouver and Trail will work with Allen and Huggins of Vernon in planning a $1,500,000 expansion program for the hospital. The addition will mean 60 new beds for the hospital.

The site has been chosen for the new King's Daughters' Hospital in Duncan which is to serve the entire Cowichan valley. Architects are Birley, Simpson and Wagg, Victoria. The cost is estimated at $2,000,000.

A private hospital is being constructed in Penticton. The single storey structure, to cost $180,000, will be operated in conjunction with the neighbouring home for the aged, Valley View Lodge. Architects for the project are Smith and McCulloch of Vancouver and Trail.

The new 125-bed hospital in Prince George was officially opened in January.

Retarded
(concluded from page 60)

this will only partially meet the need at that time. Further facilities will undoubtedly be required, particularly in view of the growing population of the province. It is hoped that these will be designed to meet the demands of the changing type of hospitalized retardate; to meet the needs of comprehensive medical care, training, and research; and that close university associations can be established. Increased understanding of the retardate and increased acceptance of this handicapped group by the community are essential. Community facilities must be increasingly developed to meet the challenge presented and to enable ever increasing numbers of this handicapped group to take a more or less productive place in the economy and permit them to live out their lives as good and happy citizens. ■

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When you equip your building with a Johnson Pneumatic Temperature Control System, Johnson wants to be certain it keeps your heating, ventilating, or air-conditioning systems operating at top efficiency for the life of your building.

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JOHNSON CONTROL

PNEUMATIC SYSTEMS

GROWING WITH CANADA SINCE 1912

Twenty Years Ago

From the Canadian Hospital, February, 1940.

Bethlehem and the A.R.P.

War has unexpected results and certainly not the most likely to be anticipated is the re-creation of the manger in Bethlehem. In a field across from the maternity wing of a hospital in England, is a queer looking structure inside of which are suspended little wooden cradles, like mangers in a stable. This is an air raid shelter to which the nurses would carry the babies in case of attack. Even in such a shelter, to quote *Hospital and Nursing Home Management*, there will live the spirit of the Christ Child. We might add, "But not on the outside, nor above it".

* * *

Sir Frederick Banting to Head Research Unit in England

Sir Frederick Banting will take charge of the research laboratory at the new military hospital which is to be erected and equipped by the Canadian Red Cross at Taplow, England. The laboratory is to be used for special research in medicine as applied to military needs.

* * *

Hospital for Sick Children Honoured

The National Foundation for Infantile Paralysis in the United States recently honoured the Hospital for Sick Children, Toronto, by the adoption of the standard splint developed at this hospital. The idea of a "splint bank", developed by the hospital in the 1937 epidemic, has also been adopted.

* * *

Hospitals Bombed in China

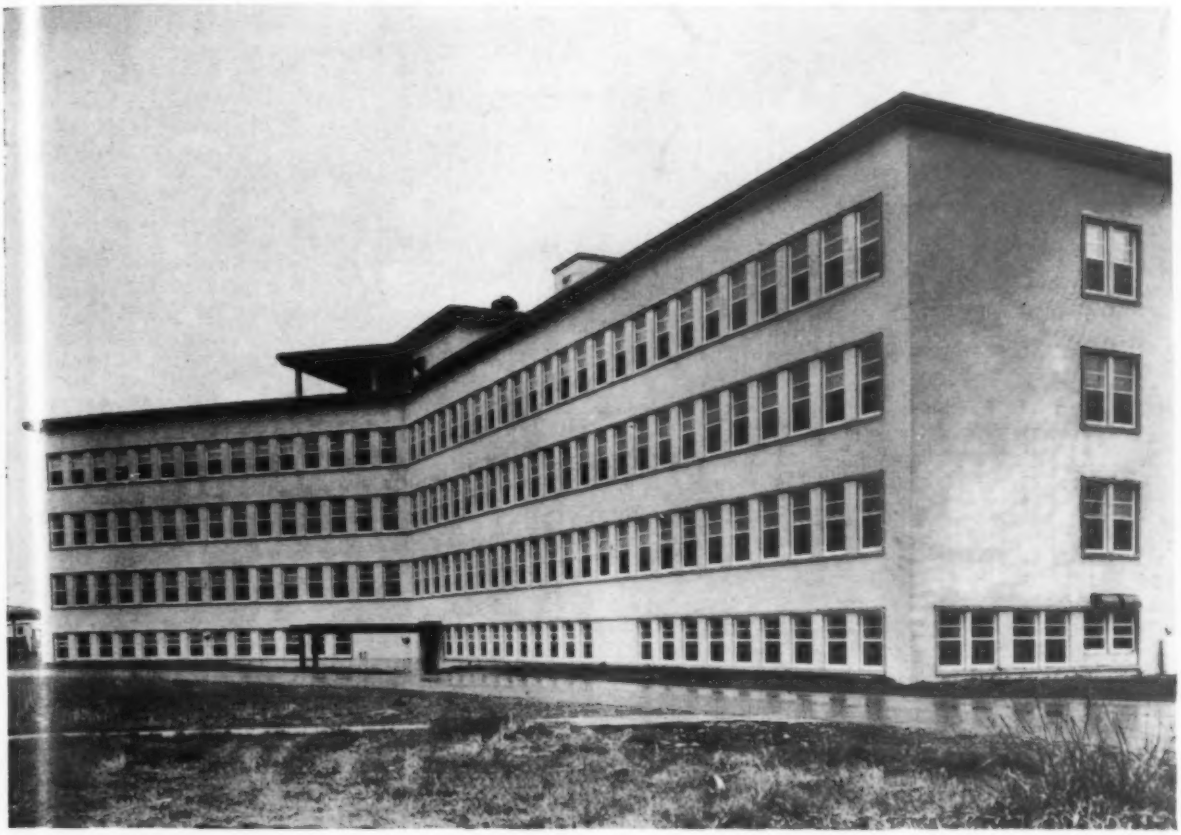
Reports from China indicate an increasing number of mission hospitals under aerial and other bombardments. In some instances it would appear that the Japanese aviators have concentrated on hospital buildings rather than to attack nearby government buildings housing Chinese officials. Several Canadians have been casualties. While this is apparently but another manifestation of the savagery and ruthlessness that has swept over totalitarian states, it is sad to reflect that these attacks have been aided by the failure of Canada to forbid sales of the necessary nickel to these aggressors and by the action of our exporters who have sold all the scrap metal they could lay hands on to Germany and Japan.

* * *

Virus is a Latin word doctors use to mean "Your guess is as good as mine."—*Bob Hope.*

HOTEL DIEU HOSPITAL, CHATHAM, NEW BRUNSWICK

ARCHITECTS: BELANGER & ROY, MONCTON



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Rusco Products (Manitoba), 1075 Ellice Avenue, Winnipeg
Wascana Distributors Ltd., 2713-13th Avenue, Regina. also: 201 C.P.R. Bldg., Saskatoon.
Capital Building Supplies Ltd., 9120-125th Avenue, Edmonton. also: 1223 Kensington Road, Calgary.
Construction Products, 5776 Beresford St., Burnaby 1, B.C.

Hospital Planning

(continued from page 64)

structures. The cost of elevators is, of course, the main reason for this.

Modern design does not always lend itself well to the hospital, especially where large areas of glass are provided from floor to ceiling. Some of the hospitals I visit have offices with a wall of glass and the drapes have to be drawn for at least the part of the day when the sun is in this direction. The rooms are insufferably hot or require air conditioning. In one hospital, a nurses' station is entirely glass covered across one side. In the summer it is so hot that the staff cannot possibly use it and have to use temporary quarters in the middle of the corridor. In the winter it is usually so cold that the nursing staff have to wear fingerless gloves and sometimes their fur coats. It is obvious that in the expansion program of the hospital, these features will not be repeated.

There is a slight tendency toward air conditioning more and more areas within the hospital. This has been increasingly apparent with surgical suites, delivery suites and nurseries, and a few of the new hospitals are providing duct space for air conditioning of all patient areas. However, there is still a tendency to believe that we live in a cold country. Therefore, the expense of air conditioning is not usually considered justifiable in spite of the weeks of 80 to 90 degree temperatures we have in some parts of the country.

Hospitals of all sizes are providing physical therapy departments these days. This is a definite trend and if staff can be obtained at all, it is fairly safe to predict that within a very few years almost all hospitals will have either a full or part time service in physical medicine.

Hospitality shops are increasing in size in all hospitals, usually under the sponsorship of the Canadian National Institute for the Blind or the women's auxiliary. Some of them have become major shopping centres within the hospital itself, much like the small town drug store.

One of the most noticeable trends is the continuing and increasing insistence by hospital boards that long range planning be developed for their institution. More and more we see that the whole physical plant is being re-

(continued on page 109)

Hospital Planning

(concluded from page 108)

viewed before making spot alterations to any one part of the hospital. There is an increasing awareness of the fact that small changes may become major impediments toward creating an effective operation at a future date. Too many hospital boards have had the experience of having to enlarge their facilities within a very few years and finding that their services were totaly inadequate to handle the increased load of patients anticipated. There is also an awareness of the importance of the services, both diagnostic and domestic, within the hospital. Many hospital boards formerly considered only the provision of hospital beds and assumed that the staff could get along as well as they always had in the past. There is, I am happy to report, an increasing knowledge of the need for providing the tools by which they may do the job. Many hospitals now plan departments with the chassis size larger than required for the beds initially provided. They can build to it in the future and not be inconvenienced or placed in the impossible position of serving a hospital much larger than their plant can handle.

These are some of the most noticeable trends in hospital planning today. I must now mention the contribution—and not just the financial one — of government officers, both federal and provincial. As you know, many of the conditions upon which construction grants are paid are mandatory and others are recommendations only. These conditions are not called trends of course but construction standards, and they have been immensely valuable in ensuring that patients will be safe from the hazards of fire and infection, and be reasonably comfortable. They also ensure that the hospital will operate in as efficient and economical a manner as possible, consistent with a high standard of care. All of us, wearing the hats of hospital people as well as potential patients, owe a debt of gratitude to most of the government officers who have helped to create and maintain the standards.

Some of today's trends will become standards in the future. The test of any trend is its contribution to better patient care and more efficient operation. It will be interesting to observe which ones measure up to the test of the years immediately ahead. ■

Classified Advertising

Advertisements for insertion should be mailed to Canadian Hospital, 57 Bloor Street West, Toronto 5, Ontario. Rates for classified advertisements are as follows:

$3.75 per column inch or fraction thereof, minimum charge $3.75. Display advertisements, set in a box, may be requested on advertisements of 2 inches or larger at no additional charge, ¼ page display advertisement—$25.00. Advertisements must be received by the first of the month to appear in that month's issue.

PHARMACIST

Required for 100 bed hospital

Not obligated to begin before June

Write

Administrator

Norfolk General Hospital

Simcoe, Ontario

Registered Medical Record Librarian

wanted, to supervise department in 160 bed hospital. Please apply to Administrator, Kirkland and District Hospital, Kirkland Lake, Ontario.

Science Instructor Required

for the Moncton Hospital School of Nursing which has a yearly enrollment of 40 students.

Salary based on qualifications, 40-hour week, good personnel policies, apply to Director of Nursing, The Moncton Hospital, Moncton, N.B.

Assistant Laundry Superintendent

For institutional plant. Apply in writing stating age, experience, qualifications and when available to: Kitchener-Waterloo Hospital Laundry Superintendent, Kitchener, Ontario.

HOSPITAL ADMINISTRATOR

Required

There is a vacancy for a fully qualified, preferably University trained Administrator for 328 bedded Sanatorium.

Please address replies to:

President,
Board of Directors,
Fort William Sanatorium,
Fort William, Ontario.

Stating Age, Qualifications, Experience, Marital Status, and Renumeration expected.

Administrative Personnel Placement Service

Mary A. Johnson Associates welcomes inquiries from Hospital Trustee and Administrative and Department Head Level Personnel for Hospital and Medical Group positions.

Dr. Johnson is trained and experienced in Hospital administration as well as Personnel Management and is available for Consultation of Personnel needs.

Our files contain many well qualified personnel as well as interesting openings.

We pride ourselves on careful screening of all clients and thorough investigation of openings. Our aim: to match the applicant and the specific position.

MARY A. JOHNSON ASSOCIATES

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Mary A. Johnson, Ph.D., Director

Director of Nursing

Modern Hospital with 42 adult beds and 11 bassinets has vacancy for Director of Nursing.

The hospital is located in a company operated town and serves a population of approximately 6,000. Community organized recreation. Residence accommodation and all conventional benefits available.

Salary commensurate with experience and qualifications. Apply giving full particulars of training and experience to:

Administrator,

Anson General Hospital

Iroquois Falls, Ontario.

Assistant Superintendent

Wanted for 73 bed General Hospital with planned expansion. Registered nurse with post graduate training and/or experience in supervision desired. Salary depending upon qualification and experience. For further particulars contact Superintendent, Kenora General Hospital, Kenora, Ontario.

EXPERIENCED HOUSEKEEPER

required by

KINGSTON GENERAL HOSPITAL

Kingston, Ontario

Housekeeping course an asset. Salary commensurate with experience and qualifications.

Applicant should state age, marital status and enclose details of past experience, including references, in a letter addressed to:

Director of Personnel

Kingston General Hospital

Kingston, Ontario

Registered Nurse Wanted

as Superintendent for 30 bed hospital with a new wing. Please state previous experience and salary expected. Starting immediately. Furnished 3 room apartment provided. Reply to the Secretary, Englehart and District Hospital Board, Box 609, Englehart, Ontario.

HAMILTON GENERAL HOSPITALS

SCHOOL OF NURSING

will have vacancies on the teaching staff in the field of

SCIENCE

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At the end of the school term The School of Nursing has a program of 2 years correlated theory and practice plus 1 year interneship for approximately 300 students.

APPLY TO:

DIRECTOR OF NURSING,
BARTON STREET EAST,
HAMILTON GENERAL HOSPITALS

Social Therapy Centre

At the Coppice Hospital, Nottingham, England, a patients' social therapy centre is being planned. It will be run entirely by the patients, and doctors and nurses will enter only by invitation. To encourage patients to re-socialize themselves, the centre is to resemble a village community in many ways, where the patients should administer it through committees or whatever other form of organization seems most suitable to them. Both in and out-patients and their relatives and friends will play an important part in learning to take part in the activities of the patients without managing them too much.—*The Hospital*

Sweden's Largest Hospital

The recent opening of a new central section at Sahlgren Hospital, Gothenburg, makes this hospital the largest in Sweden, and marks the peak of a ten year rebuilding scheme which has cost the equivalent of £7 million. The Sahlgren Hospital is a teaching hospital, serving the University of Gothenburg and now has 2,000 beds.

No less than 26 operating theatres have been built, each provided with two operating tables, the idea being to save wasted time between operations. The theatres are grouped together and isolated from the wards. Adjacent to the theatres are the blood-centre, the sterilization centre, changing rooms for the operating staff and the x-ray departments.

The x-ray department is claimed to be one of the most modern in the world. All x-ray photography is mechanized and the films are automatically exposed by means of turning a knob to the desired time of exposure. The films enter the exposing apparatus on a travelling chain and emerge after a few minutes, dry and ready to be examined. The automatized x-ray department is equipped to handle 60,000 examinations a year with a considerably reduced personnel.

The blood centre has 15-16,000 registered blood donors and handles 100 persons a day, and its serological department makes almost as many cross testings.—*The Hospital, November, 1959.*

Apples

Historians tell us that the apple was known to ancient cavemen and to the early Greeks and Romans—certainly not in the succulent form in which horticulturists give it to us today, but nevertheless with many of its desirable eating qualities.

Today, apples are a "standby" of Canadian cooks . . . for pies, sauces, baking individually, and for scores of appetizing new dishes. Too many people, however, buy apples without regard to variety and consequently fail to get the best the market affords.

There is no such thing as the typical apple flavour, as each variety has its own distinctive taste—sweet, mellow, or tart, as the case may be. Some apples are better suited for baking, some for eating out of the hand, while others make better sauce because of their flavour characteristics. —*Health.*

. . . Across the Desk

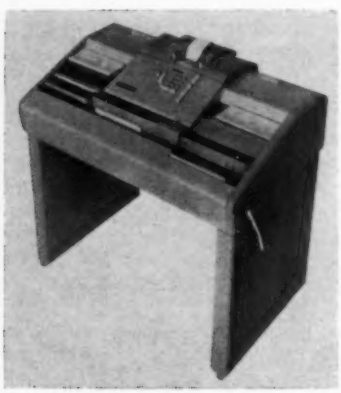
News Released by Hospital Supply Houses

By C.A.E.

McBee Data Processing System

A fully integrated data processing system for under $100 a month rental is available for revenue analysis and out-patient billing in hospitals.

The system is built around McBee's new Keysort Tabulating Punch. The machine is the first data processing tool that automatically code-punches and tabulates original records. In revenue analysis and out-patient billing, the Tab Punch provides rapid, economical and accurate accumulation of figures.



The basic document in the Keysort system is a card with coded holes in its edges. These holes can be notched to indicate many factors —class of patient, patient name and number, date, building location and examination information. In a typical hospital application, Keysort charge tickets are notched with the name, number or other control information of every patient admitted.

Additional information may be obtained from the McBee Company Limited, 179 Bartley Drive, Toronto 16.

White Mop Wringer Catalogue Available

White Mop Wringer Company of Canada, with factory and sales offices at Paris, Ont., has just published a new catalogue of floor cleaning equipment. This catalogue illustrates a complete line of mechanical floor cleaning equipment and maintenance accessories.

It presents the White line in some 20 illustrated pages with useful information on the floor maintenance applications of each of the items: wringers, squeezers, buckets, trucks, tanks, squeegees, mop sticks, dust pans, utility trucks, and mopping outfit combinations designed for hospitals, offices, factories and public buildings.

Wilmot Castle Introduces "Orthomatic" Sterilizer

A new sterilizer which features completely automatic, push button control and substantially reduced cycle time has been announced by the Wilmot Castle Company of Rochester, New York.

Called the Castle Orthomatic, the new unit replaces conventional multiple dials, handles and switches with four easily identified keyboard controls marked: Liquids, Dry Goods, Manual and Steam Off. The desired sterilizing cycle can be started by simply pressing the proper key. All subsequent phases follow automatically, with no human monitoring or human error involved, and a buzzer indicates the cycle completion. Indicating controls furnish a permanent record of temperature and pressure for each sterilizing cycle. The Orthomatic can take all loads, and cycle temperature can be varied from 220 degrees to 270 degrees F. simply by turning a calibrated dial.

High speed heating, made possible by a new electromatic jet heating system which uses full steam line pressure, raises the load to sterilizing temperature in less than half the time needed with conventional sterilizers. A new refrigerant cooling system will cool a full liquid load in an average of 20 minutes. Rapid drying is promoted by a sterile filter system which uses fresh, filtered air passed through a sterile, bacteria-retentive filter to purge the sterilizer chamber of residual steam and odours. The drying timer is calibrated to the minute so that the exact drying time required is used.

Further information on the Castle Orthomatic may be obtained by writing Wilmot Castle Company, 1939 East Henrietta Road, Rochester, New York.

Mead Johnson Infant Formula Product

Patterned after human milk, Enfalac Powder is made from nonfat milk, lactose, oleo, corn and coconut oils and soy lecithin, with added vitamins and minerals.

The caloric distribution consists of 9% from potein, 50% from fat and 41% from carbohydrate as compared with 7%, 51% and 42% respectively in average human milk. Curd tension is practically zero.

Indicated for day-by-day feeding of full term infants; feeding of premature infants; supplementary use with breast feeding; feeding of infants with poor tolerance to milk fat.

Mead Johnson of Canada Limited, 111 St. Clair Avenue West, Toronto, will be glad to supply full details.

(continued on page 114)

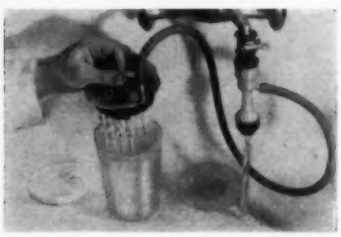
Across the Desk
(continued from page 112)

Clay-Adams New Products for the Laboratory

The Adams Pipette Washer and the Adams Aspirator, two new products for the laboratory, have been announced by Clay-Adams, Inc., New York.

The Adams Pipette Washer washes and dries as many as 18 blood diluting, Sahli, sedimentation, lambda or similar pipettes. Its unique flap valve automatically closes off holes not being used. This eliminates the time-consuming nuisance of "stop plugs".

The washer is carefully constructed of rubber and aluminum parts not affected by common laboratory reagents or washing solutions, and is easily disassembled for cleaning. It has a convenient carrying ring and comes complete with three polyethylene jars with covers.



The Adams Aspirator is a high vacuum, large capacity aspirator which will pump large fluid volumes, up to two gallons per minute, at normal city water pressure. Designed for a wide variety of laboratory uses, such as vacuum filtering, urea nitrogen tests employing the aeration method, drawing up spilled liquids and cleaning pipettes and Wintrobe tubes, it is also an ideal partner for the Adams Pipette Washer described above.

The aspirator is made of inert, corrosion resistant polyethylene and comes with a rubber universal faucet attachment which fits most standard faucets. A non-splash screen breaks up the high-pressure water stream and prevents splashing in the sink.

Addition to Maintenance System For Floors

A device which will enable janitors to obtain reasonably good results from their floor maintenance pads until they are ready to make a permanent driving pad conversion has been announced by Minnesota Mining and Manufacturing of Canada Limited.

The 3M brush band is designed to adapt present floor machine brushes for testing and evaluating the 3M floor maintenance system. Available in sizes to fit all brushes 12" through 24" in diameter, the brush band stretches over the wood brush block down onto the bristles. It provides a firm driving surface.

Made from stretchy 1½" rubber, the band is said to reduce splashing, give excellent pad support and help eliminate "creeping" or "bridging".

The company pointed out that the brush band does not replace the 3M driving pad. Rather, it has been designed to permit the use of their floor maintenance system and convert to permanent driving pads later.

New Camera for X-ray Motion Pictures

X-ray motion pictures of human organs and functions for clinical and diagnostic purposes with minimum hazard to the patient from exposure overdosage have been achieved in the Model 225 camera designed by Photomechanisms, Inc., for Picker X-Ray Corporation.

Exposure of the patient is reduced to a minimum through the device of limiting x-ray exposure only to the periods of frame sequence. An epicyclic, quick-change gear train controlled by a convenient knob on the camera housing provides frame speeds at rates of 7½, 15, 30 and 60 per second. The camera uses a 100-foot Kodak Cine special magazine which is coupled to a polarized synchronous motor drive. The drive train includes a commutator which furnishes shutter phasing information, while a

selector switch provides frame rate information. This design causes phasing between the 60-cycle power line and the camera shutter to be maintained accurately for all frame rates as well as for every motor start-up.

The camera operates as auxiliary equipment to the x-ray generator by photographing the output of an image amplifier tube, which in turn electronically intensifies the output of an x-ray excited phosphor. For optimum exposure capability, the camera is equipped with an ultra-fast F: 0.95 Angenieaux lens, having a 25 mm. focal length.

For further information on the x-ray camera, write Picker X-Ray Engineering Limited, 1074 Laurier Avenue West, Montreal.

New Pressure Switch For Electric Heat Control

Smooth, gradual control of electric heat unit ventilators in hospitals and other large buildings is provided by a new pressure-electric switch. The device, called the MS (multi-step) Switch, is made by The Powers Regulator Company, Skokie, Ill., manufacturer of automatic temperature controls. It uses a variable pneumatic signal to actuate as many as ten electric heating elements in sequence for the temperature level required.

Unlike steam or hot water heating systems, electric systems cannot be varied in temperature economically by varying the flow of electricity. Instead, several or many constant temperature resistance heating elements are used. To provide variable heat output, the resistance elements are energized or de-energized in sequence.

A single electric thermostat cannot operate all of these heating elements in sequence. This is because the thermostat has one setting and can control only one heating element. To control a multi-element electric heat unit ventilator, a multi-step device must be used.

Additional information is available in Form P-80 from the Powers Regulator Company of Canada Limited, 15 Torbarrie Road, Downsview, Ont.

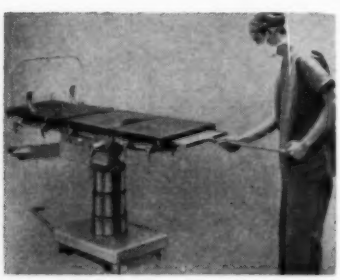
(continued on page 116)

Across the Desk
(continued from page 114)

Shampaine Company Designs New X-ray Permeable Top

The development of a new X-ray Permeable Top was announced recently by officials of the Shampaine Company. Designed as an optional accessory for the Shampaine S-1501, S-1502 and S-1503 operating tables, the new top assures high speed roentgenography during surgery.

An exclusive feature of the x-ray top is that the casette may be inserted from either side, the head end, foot end or seat section. A convenient calibrated guide rod permits the casette to be moved through the head or foot ends of the table to a predetermined position. The three individual sections of the top anchor over existing side rail spacers. This method eliminates need for holes or installation accessories that interfere with cleaning or with proper positioning of the table.



For full information write to the advertising department, Shampaine Company, 1920 S. Jefferson, St. Louis, Mo.

Standard Issues New Fire Alarm Catalogue

The Standard Electric Time Company has issued a new 36-page, two-colour catalogue covering its line of fire alarm systems for hospitals, industrial, institutional and public building. Included is complete information on the company's "March Time", master-coded, and box-coded systems. In addition, components and accessory equipment, including stations, detectors and signals, are illustrated and described. The catalogue also contains typical job specifications covering all systems.

A copy of the catalogue may be obtained by writing to Standard Electric Time Company of Canada, Limited, 726 St. Felix Street, Montreal.

Disposable Baby Tape for Measuring Infants

A disposable measuring tape recently designed by Hollister provides a safe means of measuring infants at birth. Made of sturdy moisture-resistant paper, the baby tape may be autoclaved and is disposable after use. Or it may be given to the parents as a memento.

Marked in centimeters and inches, the 26-inch tape is long enough to measure the average-sized infant for several months.

Baby tapes are useful in any hospital department where a soft, non-metal measure is desired. They can be used for measuring hydrocephalic, orthopaedic and thoracic patients, for example.

Each tape carries the hospital name, city and province. For this there is no charge. Space is provided for recording birth information and infant growth. After use, the tape may be folded and permanently affixed in the baby's book.

For further details, write to Hollister Limited, 160 Bay Street, Toronto.

Cuisine Instant Potatoes New Kraft Product

In line with a company policy to create and introduce new products that offer the food operator quality together with economy and convenience, Kraft Foods Limited is introducing an institutional size package of instant mashed potatoes.

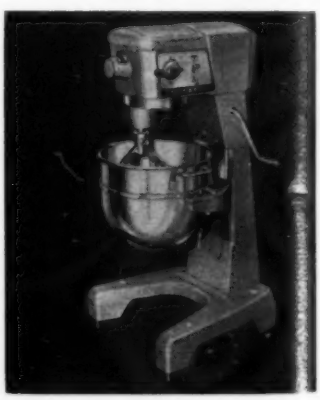
According to R. A. Munro, Kraft institutional sales manager, one No. 10 tin of their Cuisine Instant Potatoes is equivalent to 40 pounds of peeled potatoes, or 150 3-2-ounce servings. In a closely-figured comparison of costs, they have determined that when an operator spends $4.00 for a 100-pound sack of potatoes, he actually throws away $1.44. That is based on the fact that a 100 pound sack yields about 64 pounds of useable potatoes and that 36 pounds of peelings, eyes and trimmings are thrown away. In their cost estimates they have thus determined that an operator saves one-half cent per serving by using Cuisine Instant Potatoes.

Kraft lists as the outstanding

advantages of this new product: Genuine Idaho flavour and texture; stores in a fraction of the space of raw potatoes; saves time, labour and money; completely eliminates mashed potatoe waste; long steam table life; no change in colour, flavour or texture. Cuisine Instant Potatoes are said to be versatile in use for mashed potatoes, potato soup or potato patties.

New Mixer Introduced by Hobart Company

The Hobart Manufacturing Co. Limited has announced a versatile new Model D-300, 30-qt. mixer. The D-300 embodies a Hobart-built motor, centralized controls, positive speeds and Hobart planetary mixing for true-to-recipe results. A feather touch bowl lift and optional bowl truck and timer control simplify the operation of this totally enclosed and crevice-free machine.



Replacing the well-known Model S-301, the Hobart Model D-300 is equal in speed and power, superior in performance, easy to clean and compact.

Full information is available from the company at 175 George St., Toronto.

(concluded on page 118)

Advertisers Always Appreciate Hearing from Readers

Across the Desk
(concluded from page 116)

New Appointment at Ingram and Bell

Gordon A. Cornelius has been appointed manager of the Vancouver, B.C., branch of Ingram and Bell, Limited. He succeeds J. M. Cave, who retired on December 31, 1959.

Gordon A. Cornelius

Mr. Cornelius has been with Ingram and Bell Limited in various capacities for 11 years. For the past seven years he has lived in Victoria, B.C. and served as professional service representative in Vancouver Island and Northern British Columbia.

Ohio Catalogue of Apparatus and Accessories

The new Ohio-Heidbrink Anaesthesia Apparatus and Accessories Catalogue, featuring the complete line of Kinet-o-meters, is now available.

Significant features of the Kinet-o-meters are described in detail and each model is identified as to equipment and price. Illustrations of the major units show their attractive appearance and location of the various accessories. Accessories, which include the absorbers, vaporizers, rubber goods and endotracheal items, are in separate sections of the 48-page catalogue to facilitate selection and ordering.

To obtain a copy of this new catalogue, please write to Ohio Chemical Canada Limited, 180 Duke St., Toronto.

Canlab Cleaning Guide Wall Chart

It is a well established fact that a good cleaning procedure will save time and increase the life of glassware, instruments, utensils and other equipment such as rubber goods. A guide, in the form of a handy wall chart, showing how to handle the many cleaning problems found in the laboratory, is now available from Canadian Laboratory Supplies Limited, 3701 Dundas Street, West, Toronto.

Multitone Transistorized Pocket Receiver

A new series of transistorized pocket receivers has been made available for use with the Multitone "Personal Call" staff location system. Known as the Series Eight, these receivers are for use in low to medium ambient noise levels and are capable of receiving a spoken message as well as a selective call signal.

Among improvements incorporated in the re-styled receivers are greatly increased strength of the high impact plastic and aluminum case and increased sensitivity. Weight is very low at 5¾ ounces complete with mercury batteries.

For full particulars write Multitone of Canada Limited, 24 Merton Street, Toronto 7, Ontario.

Precision Weighing Machine

A new, highly important aid to open heart surgery—a precision, portable weighing machine—has been obtained by the St. Boniface Hospital, Winnipeg, Man. The reason for the importance of the scale in open heart surgery is the medical fact that a heart patient must have exactly the same amount of blood in the body after an operation, and only by weight can the proper amount be finally determined. The scale is so delicate that even the weight of two pieces of paper in a patient's hand would be shown. The instrument was given to the hospital by the women's auxiliary.

Air Shields Inc. Acquired By National Aeronautical Corp.

James M. Riddle, Jr., President of National Aeronautical Corporation and Samuel Y. Gibbon, President of Air-Shields, Inc. of Hatboro, Pa., announce that their boards of directors have adopted a plan under which Air-Shields will be acquired by National Aeronautical and operated as a wholly-owned subsidiary.

When details of the proposed transaction are finalized, 2.9 shares of NARCO will be exchanged for each of the 49,364 shares of Air-Shields common stock, which is closely held. No cash is involved. The plan will be submitted to NARCO stockholders for their approval at the annual meeting in March.

Mr. Riddle, in announcing the proposed acquisition, stated that it is in line with NARCO's plans for further diversification of its operations. NARCO is a leading manufacturer of a diversified line of commercial aviation products marketed under the trade name NARCO.

The NARCO president emphasized that no changes are planned in either management, personnel or policies of Air-Shields which will continue to operate under the direction of Mr. Gibbon.

The Air-Shields plant at Hatboro will be expanded and NARCO will establish a medical electronics engineering section in their new engineering centre at Fort Washington.

The NARCO president said that new product development now underway will be accelerated and should sharply boost Air-Shields' sales volume over the next two or three years.

Air-Shields products are widely used throughout the Free World. Export sales, excluding Canada, amount to 20 per cent of sales. Distribution in Canada is through Air-Shields of Canada, Ltd., a subsidiary.

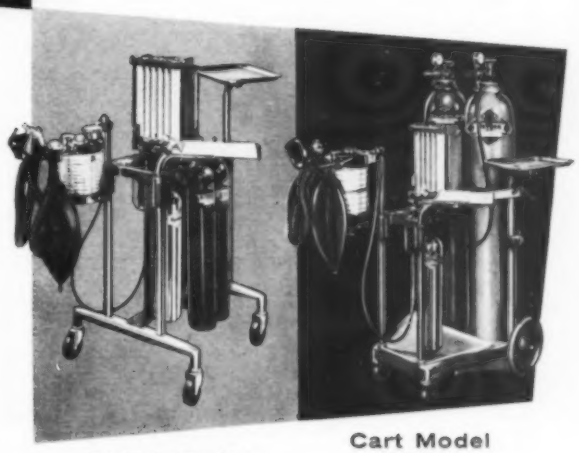
Outstanding among the many Air-Shields products is the Isolette, an incubator for the protection of new born infants. The Isolette is widely used in hospitals all over the world. Other products include air pumps for operating room and clinical use and emergency resuscitation equipment for use by ambulance, fire and police.

OHIO® HEIDBRINK® KINET-O-METERS®

Quality + Service = *Best Investment*

Since their introduction to the medical profession a half-century ago, Ohio-Heidbrink gas machines have maintained a position of pre-eminence in the field of anaesthesia. Quality-built Kinet-o-meters offer anaesthetists the ideal mechanism for the administration of general anaesthetics. The servicing of these machines is assured by Ohio Chemical representatives throughout Canada. Investment in a Kinet-o-meter pays good dividends.

TO GET YOUR complimentary copy of the new Ohio-Heidbrink Anaesthesia Apparatus and Accessories Catalog No. 4820, please direct your request to Dept. CH-2.



Stand Model 3333

Cart Model 3303

Serving the Medical Profession for Fifty Years 1910-1960

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Ohio Chemical

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